

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66465

Reg. Dist. No.

6502

1. PLACE OF DEATH a. COUNTY H. A. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY Baltimore - 03X-2			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 28 Maryland		d. STREET ADDRESS 115 Garden Ridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel Gen.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH DANIEL Fred		Last alred		4. DATE OF DEATH Month 6 Day 5 Year 1960			
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10/11/43	9. AGE (In years last birthday) 16 yrs.	IF UNDER 1YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) nd		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Alfred				14. MOTHER'S MAIDEN NAME Sylvia Levin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Annapolis Hosp. rec. room.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) While swimming with friends - Sappington Yacht Yard							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While swimming with friends - Sappington Yacht Yard					
20c. TIME OF INJURY Month, Day, Year Hour 5 - p.m. Month 6 - 5 Day 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> Sackett's Pond		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sackett's Pond		20f. (City or town) A.H.	(County) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/5/60	
EXAMINER'S NAME (Type) E. Linhardt		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE MacNutt & Son		ADDRESS 28		24a. REC'D BY REGISTRAR DATE JUN 10 1960		24b. REGISTRAR'S SIGNATURE Robert J. Mann	

TO DE
CUTE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any direction is necessary, please execute it on this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6503

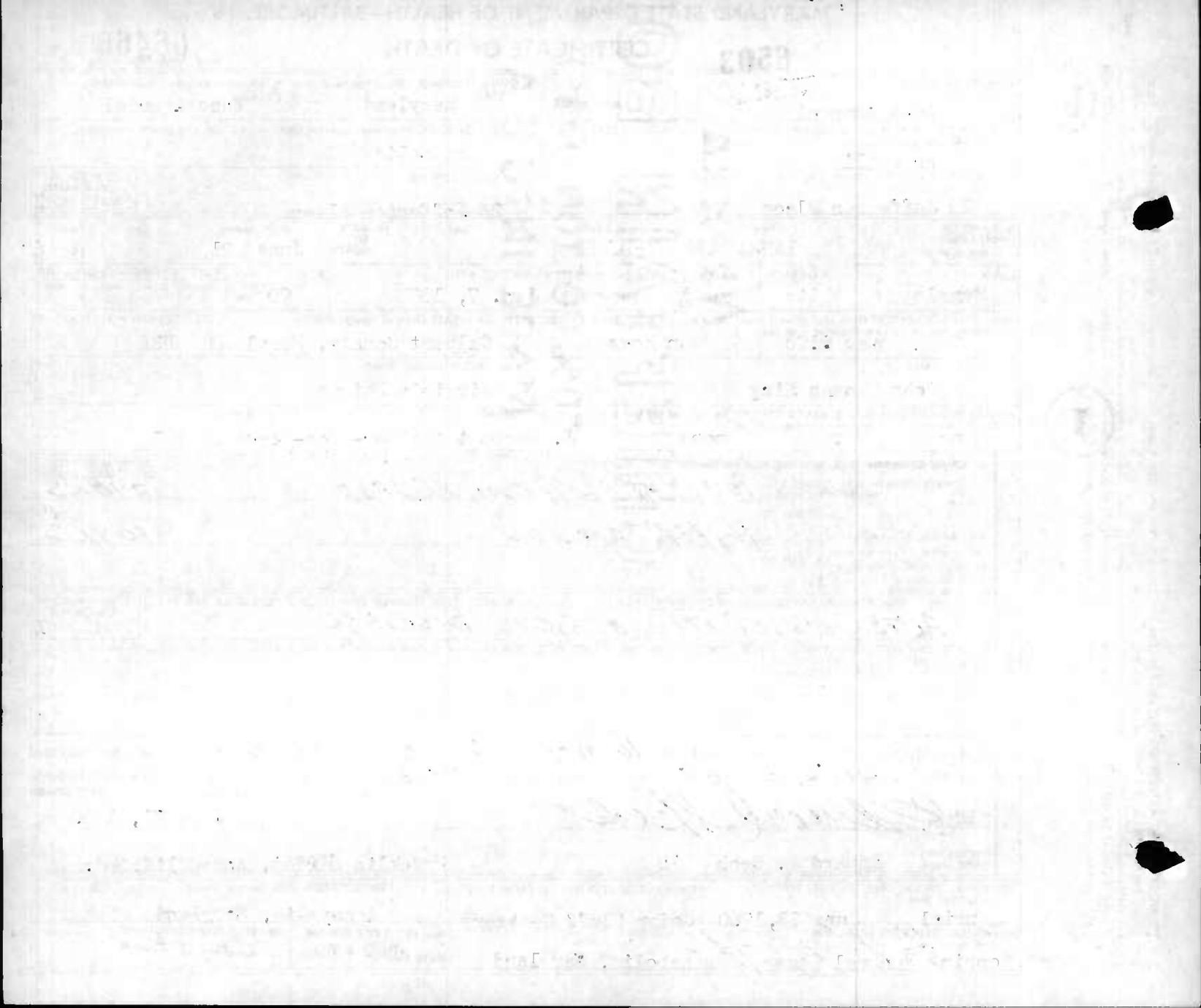
CERTIFICATE OF DEATH

Reg. Dist. No. 06466

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Jefferson Place				d. STREET ADDRESS 25 Jefferson Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LAURA M ARMIGER		First	Middle	Lost	4. DATE OF DEATH Month Day Year June 21 19 60
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1870		9. AGE (In years lost birthday) 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Calvert County, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Thomas King		14. MOTHER'S MAIDEN NAME Virginia Phipps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT J. Herbert Armiger- Son- same as # 2	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 HRS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>HYPERTENSION</i> 10 YRS (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ARTERIOSCLEROTIC HEART DISEASE</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>16 May 1960</i> , to <i>21 June 1960</i> that I last saw the deceased alive on <i>21 June 1960</i> , and that death occurred at <i>730A M</i> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>Franklin Street, Annapolis, Md.</i> DATE SIGNED <i>June 21, 1960</i>					
ACTUAL SIGNATURE <i>Edward S. Beck</i> M.D.					
PHYSICIAN'S NAME (Type) <i>Edward S. Beck MD</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF <i>June 23, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Tracy</i>		ADDRESS <i>Annapolis, Maryland</i>		24a. REC'D BY REGISTRAR DATE JUN 24 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6532

CERTIFICATE OF DEATH

Reg. Dist. No. 06467

1. PLACE OF DEATH a. COUNTY <i>AA</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. LENGTH OF STAY IN 1b <i>30 yrs.</i> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Box 161 Rt 2,</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>FRANCIS</i>	Last <i>Atwell</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>24</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 23 1890</i>
9. AGE (in years last birthday) <i>70 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	11. BIRTHPLACE (State or foreign country) <i>Shady Side, Md.</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Richard</i>	14. MOTHER'S MAIDEN NAME <i>Virginia L. Hall</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>578-10-7693</i>	INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>162.01</i> (b) <i>Brechogenic carcinoma, left lung, far advanced</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 21, 1959</u> , to <u>June 24, 1960</u> , that I last saw the deceased alive on <u>June 24, 1960</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Barber C. Palmer Jr.</i>		ADDRESS (Street, city or town, state) <i>M.D. 77 Franklin Street, Annapolis, Md.</i> DATE SIGNED <i>6/28/60</i>	
PHYSICIAN'S NAME (Type) <i>Barber C. Palmer, Jr., M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/27/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodfield</i>	22d. LOCATION (City, town, or county) <i>Walesville</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Herdeity</i>		ADDRESS <i>Halesville Md</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 5 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

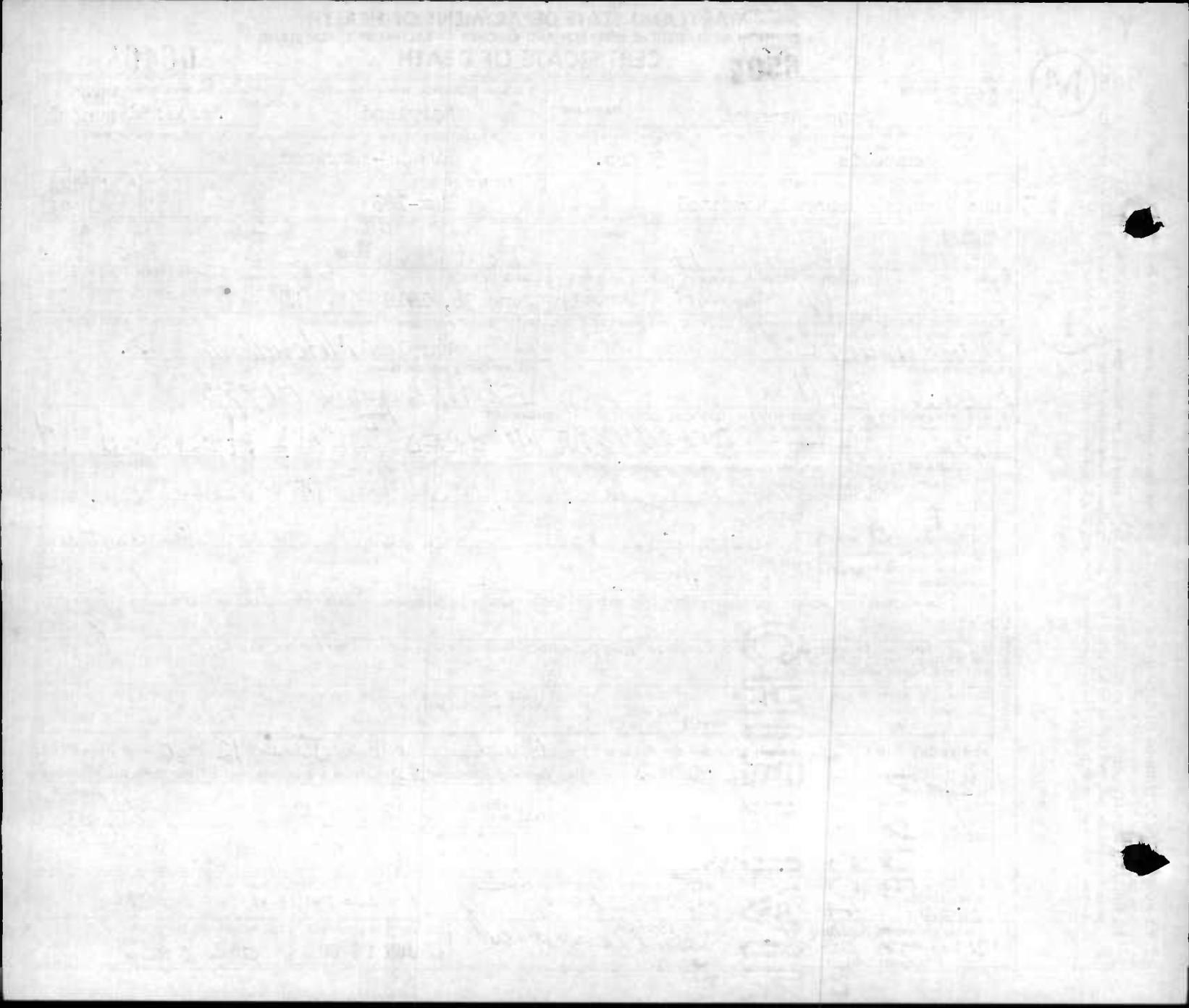
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6504 CERTIFICATE OF DEATH

06468

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Harwood	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS Box-183	
4. DATE OF DEATH Louis H Ball		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male W		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1919	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland Mitchellville U.S.	
13. FATHER'S NAME Richard Ball		14. MOTHER'S MAIDEN NAME Edith Augusta Higgs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-4895 17. INFORMANT MILDRED P. BALL Harwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis c old myocardial infarction DUE TO (c) Embolus through heart		INTERVAL BETWEEN ONSET AND DEATH 24 hours months ? 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1960 to June 12, 1960, that (I) (we) last saw the deceased alive on June 12, 1960, and that death occurred at 3 PM, from the causes and on the date stated above.		22a. SIGNATURE Willard F. Smith M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED 6/13/60		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 130015 6-15-60		23b. DATE THEREOF 6-15-60	
23c. NAME OF CEMETERY OR CREMATOR Y MIT ZION		23d. LOCATION (City, town, or county) Annapolis (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		ADDRESS Glens Falls Rd	
25a. REC'D BY REGISTRAR DATE JUN 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Item 3 Film G266 7-8-60 et

CERTIFICATE OF DEATH

06469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.C.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SEVERN</i>		b. COUNTY <i>A.A.C.</i>	
c. LENGTH OF STAY IN 1b <i>SEVERN</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>P.O. Route 1 - Box 205</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>GAMBRILLS STA. ROAD</i>		d. STREET ADDRESS <i>GAMBRILLS STA. ROAD</i>	
3. NAME OF DECEASED (Also known as First Name Middle Initial <i>John B.</i>)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <i>m.</i>	6. COLOR OR RACE <i>w.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 13-1892</i>
9. AGE (In years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>30</i>	12. Year <i>1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER RET OWN FARM.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BALTA Md</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTA Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>MARKTON BLACKOWICZ</i>		14. MOTHER'S MAIDEN NAME <i>MARY ANN (UNKNOWN)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-36-2613</i>	
17. INFORMANT <i>MRS. PELAGIA A. BLACKOWICZ</i>		Address <i>SAME AS #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>GASTRO-INTESTINAL HEMORRHAGE</i> DUE TO (c) <i>ADENO CARCINOMA, STOMACH</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>5 HRS.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>MARCH 1959</i> to <i>JUNE 1960</i> , that I last saw the deceased alive on <i>6-24 1960</i> , and that death occurred at <i>1:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leon C. Perry</i>		ADDRESS (Street, city or town, state) <i>Glen Burns, Md</i>	
PHYSICIAN'S NAME (Type) <i>Robert F. Ware - Glen Burns</i>		DATE SIGNED <i>7-1-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-4-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Our Lady of the Fields</i>	22d. LOCATION (City, town, or county) (State) <i>Millerville Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert F. Ware - Glen Burns</i>	ADDRESS <i>1001 E. 36th Street</i>	24a. REC'D BY REGISTRAR DATE JUL 5 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06470
Reg. Dist. No.FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>A.A. County Maryland</i>		<i>Maryland A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Annapolis Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. General Hospital</i>		d. STREET ADDRESS <i>16 Parole Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>Brooks</i>
4. DATE OF DEATH		Month <i>6</i>	Day <i>17</i>
5. SEX		6. COLOR OR RACE <i>Male Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>10-5-1959</i>		9. AGE (in years last birthday) yrs. <i>8</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jeremiah Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Clogget</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ruth Brooks, 16 Parole St. Annapolis</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <i>491X</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <i>E. Lashcraft Jr.</i>	
ACTUAL SIGNATURE <i>E. Lashcraft Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-20-1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Pine Lawn Memorial Best Gate Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Best Gate Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reesett. Funeral Dir.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 21 '60</i>	
ADDRESS <i>2063 349 X V 6</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

AT 11:00 AM ON THE 20TH DAY OF JUNE, 1942, I, ERNEST H. GIBSON, RESIDENT AGENT IN CHARGE, BUREAU OF INVESTIGATION, FEDERAL BUREAU OF INVESTIGATION, WASHINGTON, D. C., MADE A SEARCH OF THE PREMises OF THE BOSTON HOTEL, BOSTON, MASSACHUSETTS, AND FOUND THE FOLLOWING:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be reviewed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06471				
6534 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. LENGTH OF STAY IN lb 8 mo. 2 yrs. 16 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					d. STREET ADDRESS 2011 Walbrook Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First John	Middle E.	Last Brown	4. DATE OF DEATH 6		Month	27	Day	1960	Year			
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male	Negro	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	1909 - April 27	51		Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Brown					14. MOTHER'S MAIDEN NAME Blanche Bishop									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address								
Yes		217-05-1700		Hospital Records										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 71sx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Septicopyemia (c) Decubital Ulcers, Infected										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Wernicke's Syndrome										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----										
		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----		
21. I certify that I attended the deceased from 4/22 , 19 52 , to 6/27 , 19 60 , that I last saw the deceased alive on 6/27 , 19 60 , and that death occurred at 3:40A.M. from the causes and on the date stated above. ACTUAL SIGNATURE: Hildegard Heard Reissman PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.		ADDRESS (Street, city or town, state) ----- M.D. Crownsville State Hospital, Md. 6/27/60												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/60		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE F. Holstead		ADDRESS 918 Dundalk Lane		24a. REC'D BY REGISTRAR DATE JUN 29 '60		24b. REGISTRAR'S SIGNATURE Cynthia L. Kraus								

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18															
CERTIFICATE OF DEATH															
06472 Reg. Dist. No. ✓															
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>x Seco Md.</u> b. COUNTY <u>x Balto.</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Arbutus</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 111 Route 2 Point Pleasant</u>				d. STREET ADDRESS <u>x 314 Stevens Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary Jane Brown</u>				First	Middle	Last	4. DATE OF DEATH <u>June 12</u>	Month	Day	Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/65</u>				9. AGE (In years lost birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Woodstock, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Rueben Cavey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Strebach</u>				INFORMANT <u>Mrs. Maude Forney (daughter)</u>				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Maude Forney (daughter)</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>5</u> INTERVAL BETWEEN ONSET AND DEATH															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO ?															
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/7/60</u> , 19, to <u>6/12/60</u> , 19, that I last saw the deceased alive on <u>6/12/60</u> , 19, and that death occurred at <u>5.20 P.M.</u> from the causes and on the date stated above.															
ADDRESS (Street, city or town, state) <u>Glen Burnie, A.A. Md.</u> DATE SIGNED <u>6/13/60</u>															
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>															
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> Glen Burnie, A.A. Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/60</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town or county) <u>Granite, Md.</u> (State)									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Krause</u>				ADDRESS <u>4101 Emerson Rd., Beltsville</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '60</u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>															

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10. *U. S. Fish Commission, Annual Report, 1881*, p. 10.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G265 6-25-60 et

06473

6536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i>	c. LENGTH OF STAY IN 1b <i>2.56</i>	b. COUNTY <i>A. A.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 497 Rte #5</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i>	
d. STREET ADDRESS <i>Box 497 Rte #5</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>MELVINA</i>	Middle <i>Elizabeth</i>	Last <i>Brown</i>
4. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/20/1889</i>
9. AGE (In years last birthday) yrs. <i>91</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	11. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	12. BIRTHPLACE (State or foreign country) <i>A. A. Co. Md</i>
13. FATHER'S NAME <i>Wm Edward Smith</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Bolden</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Albert E. Smith - Pasadena Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASC. DISEASE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>443X</i> (b) <i>CHRONIC NEPHROSCLEROSIS</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>UREMIA</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>APRIL 20, 1960</i> , to <i>JUNE 19, 1960</i> , that I last saw the deceased alive on <i>JUNE 15, 1960</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur Lankford Jr</i>	M.D.	ADDRESS (Street, city or town, state) <i>Mountain Rd</i>	DATE SIGNED <i>June 19, 1960</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/22/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Not Zion Church</i>
22d. LOCATION (City, town, or county) <i>Magrath - Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marlene P. Hayes</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 20 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Turner</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. *Alouatta palliata* (Cope)
2. *Alouatta seniculus* (Cope)
3. *Alouatta caraya* (Cope)
4. *Alouatta seniculus* (Cope)
5. *Alouatta palliata* (Cope)
6. *Alouatta palliata* (Cope)
7. *Alouatta palliata* (Cope)
8. *Alouatta palliata* (Cope)
9. *Alouatta palliata* (Cope)
10. *Alouatta palliata* (Cope)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06474
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE NEW YORK		b. COUNTY Monroe	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G MEADE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROCKPORT		d. STREET ADDRESS 167 MAIN ST	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. ARMY HOSPITAL, FORT MEADE Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle C. T.	Last BUSH	4. DATE OF DEATH	Month JUNE	Day 3	Year 1960
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-23-39	9. AGE (in years last birthday) 21 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY STUDENT		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles T. Bush				14. MOTHER'S MAIDEN NAME Margaret Button			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Father (Charles T. Bush 167 Main St		Address Brockport N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN INJURY DUE TO 825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) AUTO ACCIDENT BALT-WASH PKWY AT #175					
20c. TIME OF INJURY Month, Day, Year Hour 2 o. m. p. m. 3 JUNE 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PARKWAY		20f. (City or town) (County) (State) PARKWAY & HWY #175	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED 3 JUNE 60					
EXAMINER'S NAME (Type) GUSTAVE H FAUBERT		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF JUNE-6-1960		22c. NAME OF CEMETERY OR CREMATORIAL Loydon Park Crematory		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard T. Lighter</i>		ADDRESS 166 Bonnie, Md.		24d. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE <i>R. T. Lighter</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute it on a separate sheet of paper, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or cremation.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6538

CERTIFICATE OF DEATH

06475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		a.a. Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hanover, Md.		c. LENGTH OF STAY IN 1b		a. STATE Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				70 yrs.		b. COUNTY a.a. Co.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Howard		S.		Butler	June	25	19	60
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/20/1890			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Railroad Laborer		Baldreding		Dorsey, Md.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Dennis Butler		Evaline Culver						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No				Irene B. Hebron - Box 300 Hanover, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 20 min.		
		DUE TO		Quadriplegia		21 months-		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)		Automobile Accident.		9 months		
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		car ran in back of truck. It was thrown out				
20c. TIME OF INJURY Hour / a. m. 9 / p. m. 11 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington Expressway		20f. (City or town) A.A.		(County) (State) Md.
21. I certify that I attended the deceased from _____		Mar. 12, 1960		to _____		June 25, 1960		DATE SIGNED 6/25/60
alive on _____		1960		and that death occurred at		77a M.D.		ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		Frank E. Shibley		Frank E. Shibley		Savage, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)
Burial		6-25-60		St. Mary's		Hanover, A.A. Comd.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
George E. Nelson		1348 N. Calhoun		DATE 27 '60		Orin G. Shibley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 Film G265 6-20-60 et
6539 CERTIFICATE OF DEATH

06476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Campbell.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Meade		c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elijah	Middle W.	Last Callahan		
4. DATE OF DEATH June 13	Month	Day	Year 1960		
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3-1883		
9. AGE (in years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Dauphin Co. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME James A. Callahan		14. MOTHER'S MAIDEN NAME Martha Harris		Address Margueret Callahan 720 Euclid Ave.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Margaret Callahan	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO		CORONARY THROMBOSIS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		SCLEROTIC CARDIOVASCULAR D.			
(c) DUE TO		HYPERTENSIVE VASCULAR DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from alive on 6/13/1960, and that death occurred at 3:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) P.O. Box 97 Odenton, Md. DATE SIGNED 6/13/1960			
ACTUAL SIGNATURE Peter Freuler, M.D.					
PHYSICIAN'S NAME (Type) Peter Freuler, Febus Gavaberg					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 June 1960		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Lynchburg, Va.					
23. FUNERAL DIRECTOR'S SIGNATURE R.V. Singleton		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '60	
				24b. REGISTRAR'S SIGNATURE Alvin S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06477

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>10 days</i>	b. COUNTY <i>Anne Arundel</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>112 Archwood Ave</i>		d. STREET ADDRESS <i>112 Archwood Ave</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Ellen J Cole</i>	First <i>Ellen</i>	Middle <i>J</i>	Last <i>Cole</i>					
4. DATE OF DEATH <i>6-20 1960</i>	Month <i>6</i>	Day <i>20</i>	Year <i>1960</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-24-1878</i>					
9. AGE (In years <i>81</i> <i>by birthday</i>) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>						
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>						
13. FATHER'S NAME <i>Michael F. Quinn</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Gannon</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>✓</i>		16. SOCIAL SECURITY NO. <i>- - -</i>						
17. INFORMANT <i>Mary M. Cole</i>		Address <i>(2)</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.01</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis-Cardi-Vascular Disease</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>June 19 1960</i> to <i>June 20, 1960</i> , and that death occurred on <i>June 20, 1960</i> M, from the causes and on the date stated above.				ACTUAL SIGNATURE <i>Albert L. Anderson</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md</i>		
PHYSICIAN'S NAME (Type) <i>ALBERT L. ANDERSON</i>				DATE SIGNED <i>6/24/60</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 22-1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's Cemetery</i>		22d. LOCATION (City, town, or county), (State) <i>Annapolis Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gilm. M. Taylor Sons Annapolis Md</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>June 22 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

84. BROWNSTAD - MELISSA BO THE WILDERNESS STATE OF ILLINOIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G266 7/5/60 iwk

06478
Reg. Dist. No.

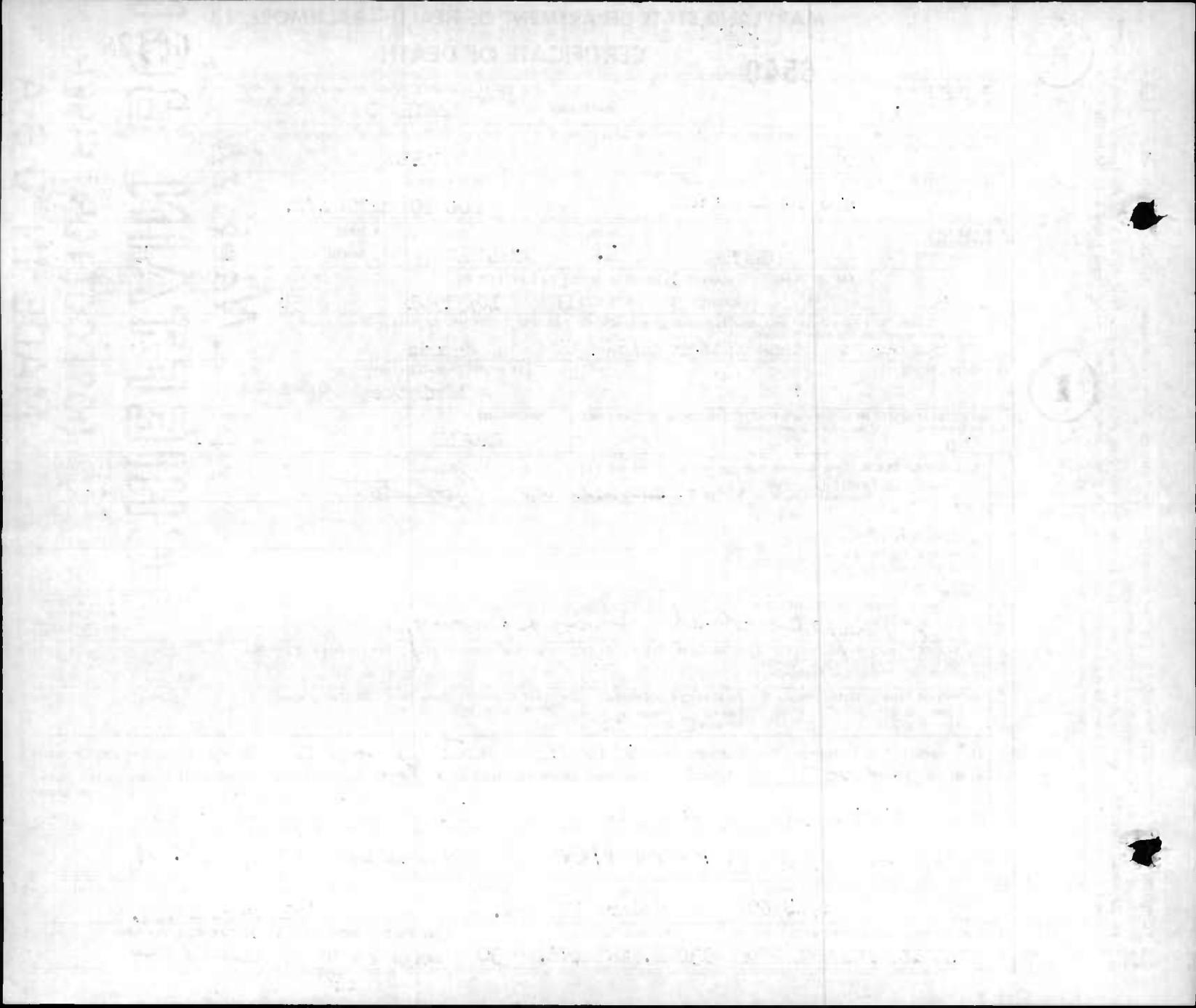
CERTIFICATE OF DEATH

6540

1. PLACE OF DEATH o. COUNTY AA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN		c. LENGTH OF STAY IN 1b RURAL and give nearest town 50 BROOKLYN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 TOWNSEND AVE		e. STREET ADDRESS 406 TOWNSEND AVE.	
3. NAME OF DECEASED (Type or print) GEORGE		First H.	Middle CORBMAN
4. DATE OF DEATH 6 25 1960	Month 6	Day 25	Year 1960
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/01
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Agent Steam fitter union 438		10b. KIND OF BUSINESS OR INDUSTRY Canada	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Miniette unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. FAMILY	
		INFORMANT SAME	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial fibrillation		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 11 , 19 58 , to June 25 , 19 60 . That I last saw the deceased alive on July 25 , 19 60 , and that death occurred at 1 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4321 Stanford Rd Baltimore 14 Md.	
ACTUAL SIGNATURE Daniel Miller		DATE SIGNED Aug 28 1960	
PHYSICIAN'S NAME (Type) Dr Daniel - Miller			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 6/28/60	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE MCCULLY FUNERAL HOMES 130 E.FORT AVE. # 30		24a. REC'D BY REGISTRAR JUN 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

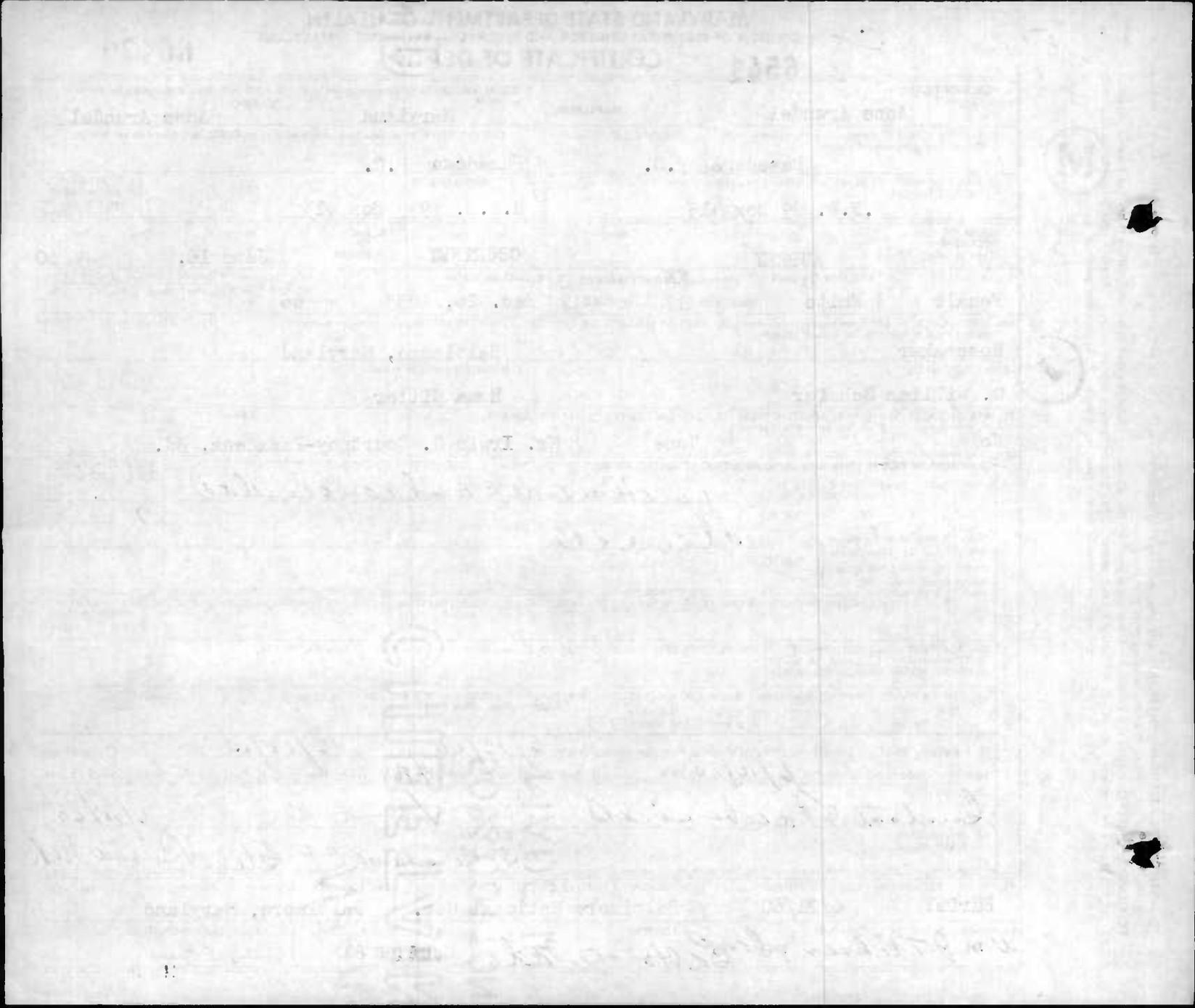
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6541

CERTIFICATE OF DEATH

06429

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b P.O.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS P.O.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #9 Box 413				d. STREET ADDRESS R.F.D. #9 Box 413		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) AUDREY		First	Middle	Last	4. DATE OF DEATH JUNE 18, 1960	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 26, 1893	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME G. William Schafer				14. MOTHER'S MAIDEN NAME Emma Miller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Irwin G. Courtney-Pasadena, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO hypertension cardiovascular INTERVAL BETWEEN ONSET AND DEATH ?								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diseases - (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/16/60 19 to 6/18/60 19, that (II) (we) last saw the deceased alive on 6/16/60 19, and that death occurred at 4 A.M. from the causes and on the date stated above.								
22a. SIGNATURE Sentor & Paesbernd, Inc.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/18/60			
22c. PHYSICIAN'S NAME (Type) Arthur S. Klein, M.D.		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tichner & Son		ADDRESS Baltimore - 7, Md.		25a. REC'D BY REGISTRAR JUN 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Klein		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6542

CERTIFICATE OF DEATH

06480

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
A.A. MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL & give nearest town Severon	24 yrs.	d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) o. INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Box 267 - R2			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Harry	Kelvin	Crawford	4. DATE OF DEATH
5. SEX m	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 11-1906
9. AGE (In years lost birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Trucks.	11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Crawford	14. MOTHER'S MAIDEN NAME Annie Beis	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. 114-40-5830	17. INFORMANT Lottie Crawford - severn	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 163X Cancer of Lungs - 1-2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Metastatic Ca of intestine - 6 mo - (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19	19	Linthicum	Md.
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Chas. L. Ball, Jr. M.D. Linthicum Md. DATE SIGNED 6/30/60			
PHYSICIAN'S NAME (Type)			
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-4-1960	22c. NAME OF CEMETERY OR CREMATORIUM Men Haven Cemetery	22d. LOCATION (City, town, or county) Roxbury
23. FUNERAL DIRECTOR'S SIGNATURE Robert F. Ware - Glen Burnie		24a. REC'D BY REGISTRAR DATE JUL 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

DEPARTMENT OF HIGHER EDUCATION - STATE OF MASSACHUSETTS

CHARTER OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG267 7-20-60 et
6543

CERTIFICATE OF DEATH

Reg. Dist. No.

66481

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn RE</i>		c. LENGTH OF STAY IN 1b <i>32 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn RE</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Somerset Ave., Belmont</i>		d. STREET ADDRESS <i>Somerset Ave.,</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Thomas</i>	Middle <i>L.</i>	Last <i>D. Hy. St.</i>	4. DATE OF DEATH Month <i>June</i>	Day <i>16,</i>	Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1888</i>	9. AGE (In years last birthday) yrs. <i>71</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>		Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cemetery Worker (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Glen Haven Cemetery</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Ditty</i>		14. MOTHER'S MAIDEN NAME <i>Darcus A. Clark</i>		Address <i>Same As Father</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>131-18-0890</i>		17. INFORMANT <i>Mr. Charles Ditty</i>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153.0</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.</i> (b) DUE TO (c)		Circumstance Circumstances			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glen Burnie</i>		20f. (City or town) <i>Glen Burnie</i>	(County) <i>Md.</i>
20f. (City or town) <i>Glen Burnie</i>		(County) <i>Md.</i>		(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>April</i> , 19 <i>60</i> , to <i>June</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 11</i> , 19 <i>60</i> , and that death occurred at <i>94</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>204 Glen Hwy</i>							
ACTUAL SIGNATURE <i>Charles R. McDonald</i>		M.D.		DATE SIGNED <i>6-17-60</i>			
PHYSICIAN'S NAME (Type) <i>Charles R. McDonald</i>		ADDRESS <i>Glen Burnie, Md.</i>		DATE <i>17 June 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>20th June 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Glen Haven Cem.</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.V. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Tracy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

DEPARTMENT OF STATE PRACTICING STATE OF HAWAII - CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

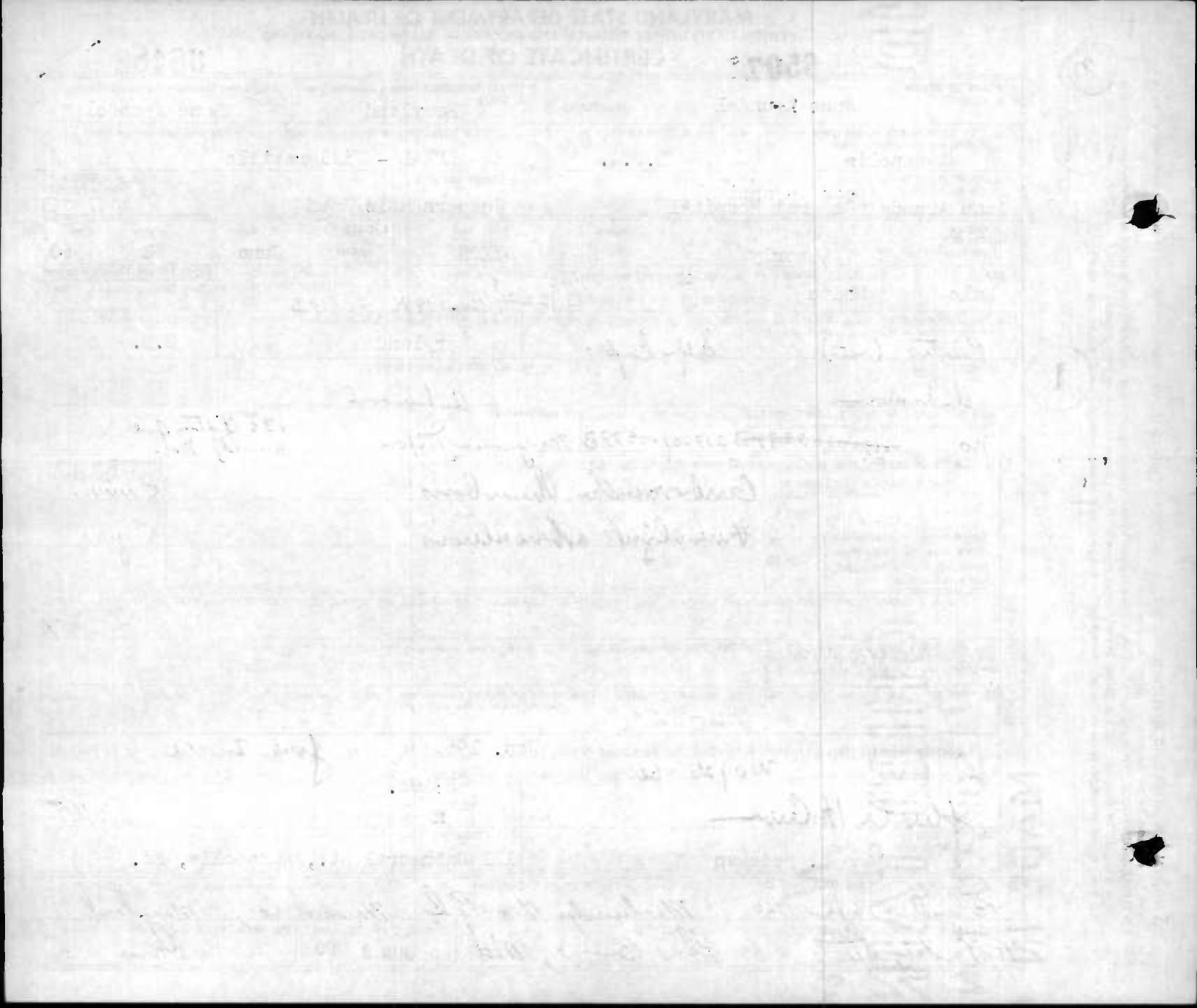
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

650?

CERTIFICATE OF DEATH

06482

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Beverly	Middle 	Last DIXON	4. DATE OF DEATH 22 Aug 1886	Month June	Day 2	Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 22 Aug 1886	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Self-Emp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-01-0999B		17. INFORMANT Mr. James Dixon		Address 136 Gifton Ave Annapolis Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gerbervascularclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hemodialysis</i> DUE TO (c) <i> </i>								
INTERVAL BETWEEN ONSET AND DEATH 5 min.								
5 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to June 2, 1960, that (I) (we) last saw the deceased alive on May 26, 1960, and that death occurred at 6:40A.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>John L. Hedeman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/60				
22c. PHYSICIAN'S NAME (Type) John L. Hedeman		22d. ADDRESS 121 Cathedral St., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 June 1960		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meadowridge Mem. Park		23d. LOCATION (City, town, or county) Howard Co., Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. V. Singletor</i>		25a. REC'D BY REGISTRAR DATE JUN 8 '60 25b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6508

CERTIFICATE OF DEATH

06483

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b 5 hours	b. COUNTY Maryland	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Severn		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)	First George	Middle Albert	Last DOWNS		
4. DATE OF DEATH June 12 1960	Month June	Day 12	Year 1960		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1885		
9. AGE (In years last birthday) 74	10. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Dorows	14. MOTHER'S MAIDEN NAME Alas Jenkins	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 10	17. INFORMANT Anthony Dorows	Address W. River Rd	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO (c) 		
INTERVAL BETWEEN ONSET AND DEATH 0 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from 6/12 1960 to 6/12 1960 , that (I) (we) last saw the deceased alive on 6/12 1960 , and that death occurred at M , from the causes and on the date stated above.					
22a. SIGNATURE John L. Hedeman			M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) John L. Hedeman			22d. ADDRESS 121 Cathedral St., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-17-1960	23b. DATE THEREOF 6-17-1960	23c. NAME OF CEMETERY OR CREMATORIAL Chesapeake Cremation	23d. LOCATION (City, town, or county) Owensville Md.		
24. FUNERAL DIRECTOR'S SIGNATURE William Reesett	ADDRESS Annapolis Md.	25a. REC'D BY REGISTRAR DATE JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

18106

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

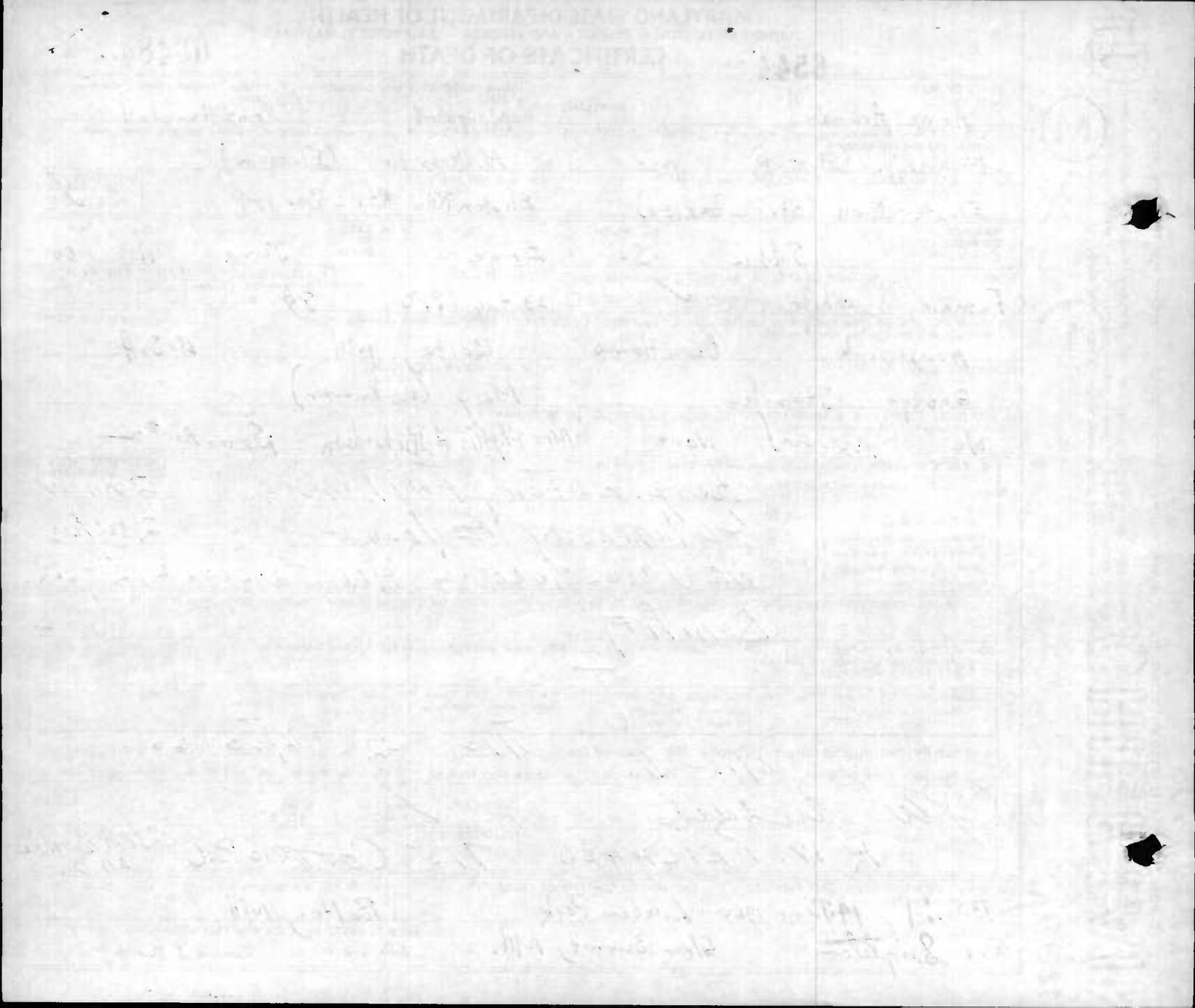
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06484

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville (Elkton)</i>		c. LENGTH OF STAY IN 1b <i>4 yrs-</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Millersville (Elkton)</i>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Elkton Road (Rt. 1 - Box 182)</i>		e. STREET ADDRESS <i>Elkton Rd. Rt 1 - Box 182</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Sophia</i>		First <i>S.</i>	Middle <i>Eme</i>	Last <i>Engle</i>	4. DATE OF DEATH <i>June 11 1960</i>	Month <i>June</i>	Day <i>11</i>	Year <i>1960</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>23 Aug 1870</i>		9. AGE (In years last birthday) yrs. <i>89</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	13. Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>George Stenke</i>		14. MOTHER'S MAIDEN NAME <i>Mary (Unknown)</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Phyllis A. Richardson</i>		Address <i>Name As # -</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>		DUE TO <i>Pulmonary Edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 min</i>									
		(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Pneumonia</i>		DUE TO <i>Atherosclerotic Heart Disease</i>		2 weeks									
		(c) <i>Senility</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>MD</i>		(State) <i>MD</i>	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, _____, and that death occurred at _____ M, from the causes and on the date stated above.															
22a. SIGNATURE <i>R.W. Richardson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/15/60</i>							
22c. PHYSICIAN'S NAME (Type) <i>R.W. RICHARDSON</i>		22d. ADDRESS <i>715 Cotter Rd Glen Burnie MD</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>14 June 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>London Park</i>		23d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>									
24. FUNERAL DIRECTOR'S SIGNATURE <i>R.V. Singletown</i>		ADDRESS <i>Glen Burnie, MD.</i>		25a. REC'D BY REGISTRAR DATE JUN 15 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06485

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selby-on-the-Bay		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selby-on-the-Bay				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fifth Avenue		d. STREET ADDRESS Fifth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) H. Franklin Knott		First VERNA	Middle FRANKLIN	Lost	4. DATE OF DEATH June 30 1960	Month June	Doy 30	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1910		9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner		10b. KIND OF BUSINESS OR INDUSTRY Cotton Textile		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Knott		14. MOTHER'S MAIDEN NAME Martha Arrington		Address 2				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT James H. Franklin				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		DUE TO 173.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Metastatic carcinomatosis of bladder & kidney		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 months				
(c) Primary carcinoma of right ovary		DUE TO 3 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rt. 1, Box 277-M	(County) Edgewater	(State) Md.	
21. I certify that I attended the deceased from March 5, 1960 , to June 30, 1960 , that I last saw the deceased alive on June 30, 1960 , and that death occurred at 7 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Sylvia M. Linn M.D. ADDRESS (Street, city or town, state) Edgewater, Md. DATE SIGNED July 2, 1960								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1960	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest		22d. LOCATION (City, town, or county) Annapolis, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons Annapolis, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

622

MURKIN

MURKIN

MURKIN

MURKIN MARY ANN

BALTIMORE CITY

BALTIMORE CITY

BALTIMORE CITY

BALTIMORE CITY

BALTIMORE CITY

BALTIMORE CITY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6546

CERTIFICATE OF DEATH

Reg. Dist. No. 06486

1. PLACE OF DEATH a. COUNTY <i>AA</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Ma</i>		b. COUNTY <i>AA</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gambrells</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gambrells</i>		d. STREET ADDRESS <i>PO Box 504 Defence Highway</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PO Box 504 Defence Highway</i>				d. STREET ADDRESS <i>PO Box 504 Defence Highway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Otto</i>	Middle <i></i>	Last <i>Fricke</i>	4. DATE OF DEATH <i>6 - 10 - 1960</i>	Month <i>6</i>	Day <i>10</i>	Year <i>1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 13 1898</i>		9. AGE (In years lost, birthday) <i>62 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>					
13. FATHER'S NAME <i>Albert Fricke</i>		14. MOTHER'S MAIDEN NAME <i>Emma Reimer</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>218-30-3411</i>		17. INFORMANT <i>Martha Fricke</i>		Address <i>(2)</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Colon angiocarcinoma</i> DUE TO <i>liver</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 1/2 mo</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastases</i> (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Annapolis</i>		(County) <i>Annapolis</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>3-29</i> , 19 <i>62</i> , to <i>6-10</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>6-10</i> , 19 <i>62</i> , and that death occurred at <i>5</i> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Edith Rodler</i>		M.D.		ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis Md.</i>		DATE SIGNED <i>6-13-60</i>					
PHYSICIAN'S NAME (Type) <i>EDITH RODLER</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-13-1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Memorial</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 14 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G266 7/5/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 06487

6547

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i> b. COUNTY <i>Ar. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4710 Ritchie Hwy</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>50 ARUNDEL Co - ANN</i>		e. STREET ADDRESS <i>14710 Ritchie Hwy</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>THOMAS</i>	Middle <i>G. George</i>	Last 4. DATE OF DEATH <i>6-16 1960</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>75 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Greece</i>
13. FATHER'S NAME <i>George</i>		14. MOTHER'S MAIDEN NAME <i>Gregoria Preneas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Pulmonary Edema</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Coronary Thrombosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 16, 1960</i> , to <i>June 16, 1960</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 16, 1960</i> , and that death occurred at <i>118</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3904 S. Hanover St. Baltimore 25, Md.</i>	
ACTUAL SIGNATURE <i>Eugene Schnitzer</i>		DATE SIGNED <i>6-18-60</i>	
PHYSICIAN'S NAME (Type) <i>Eugene Schnitzer, M.D.</i>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-20-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Greek, Evangelismos</i>
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lambros Inc. 440 E. North</i>		24a. ADDRESS <i>JUN 22 1960</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01 JOURNAL OF THE UNITED STATES OF AMERICA

... was ordered about 3 hours
ago. I am still here.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06488

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 25 yrs. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 506 Elder, N.W.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mark		First	Middle	Last	4. DATE OF DEATH Grant	Month	Day	Year			
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles H. Grant		14. MOTHER'S MAIDEN NAME Mary Dixon									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia, Hypostatic (c) Ca of Prostate Gland											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 While at work <input type="checkbox"/> at work <input type="checkbox"/> p. m. -----		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred of _____, at _____, on _____, 19_____, that (I) (we) lost		5/15 1935 6/14 1960		1:00 A.M.		1960		that (I) (we) lost		1960	
22a. SIGNATURE L. Benedict, M. D.		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/14/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 6/15/1960		23c. NAME OF CEMETERY OR CREMATORIAL University of MD		23d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE William Reese II Washington St.		ADDRESS 108 Oscar		25a. REC'D BY REGISTRAR DATE JUN 20 '60		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06489

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A. A. Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i>		b. COUNTY <i>A. A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. LENGTH OF STAY IN lb <i>3 mos, 12 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn</i>		d. STREET ADDRESS <i>Delmot Rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kollywood Manor</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Grayling Jr.</i>		First	Middle	Last	4. DATE OF DEATH Month <i>6</i> Day <i>29</i> Year <i>1960</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>6/26/1888</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Motion Picture oper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Alen Moorey</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore City, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>C.S.A.</i>	
13. FATHER'S NAME <i>John Grayling Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Vogle</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-03-9712</i>		17. INFORMANT <i>John Grayling III</i>		Address <i>Severn</i>	
(If yes, give war or dates of service)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes</i> DUE TO <i>Acute Cardiac Failure with complete circulatory collapse</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Confusion left leg back pain</i> (c) <i>Cardio vascular Disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Arteriosclerosis</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Alen Moorey</i>		20f. (City or town) <i>Owings Mills</i>	(County) <i>Md.</i>
p. m.						(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>June 10, 1960</i> to <i>June 29, 1960</i> that I last saw the deceased alive on <i>June 18, 1960</i> , and that death occurred at <i>Alen Moorey</i> M.D. ADDRESS (Street, city, or town, state) <i>Owings Mills, Md</i> DATE SIGNED <i>7-1-60</i>							
ACTUAL SIGNATURE <i>Joseph Lipskey</i>		PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-2-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) <i>Alen Moorey</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simpson Funeral Home Robert Moore</i>		ADDRESS <i>Glen Haven Cemetery</i>		24a. REC'D BY REGISTRAR <i>E. Glen Moore</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
				DATE <i>July 5 '60</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06490

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		1653-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				d. STREET ADDRESS 816 Coby Lane Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Albert Gross		First	Middle	Lost	4. DATE OF DEATH June 10,	Month	Day	Year 19 60
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 1894	9. AGE (In years lost, birthday) 96 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Luellen Gross				14. MOTHER'S MAIDEN NAME Annie ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-07-2165		17. INFORMANT Mrs. Smith-Social Worker-Prince George Hosp.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO <u>443X</u>						INTERVAL BETWEEN ONSET AND DEATH ? yrs.		
Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause lost. } (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from May 16, 1960, to June 10, 1960, that I last saw the deceased alive on June 5, 1960, and that death occurred at 3:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>James M. Pair</u>						ADDRESS (Street, city or town, state) M.D. 400 N. Carrollton Ave.		DATE SIGNED June 10, 1960
PHYSICIAN'S NAME (Type) James M. Pair, M.D.				Baltimore 23, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-60		22c. NAME OF CEMETERY OR CREMATORIAL ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. Snover		ADDRESS		24e. REC'D BY REGISTRAR DATE MAY 16 1960		24b. REGISTRAR'S SIGNATURE Sister L. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

53

1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

6509

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF
DECEASED
(Type or print)

First
WILLIAM

Middle
W.

Last
GROSS

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

6-28-1937

9. AGE (In years
last birthday)

22
yrs.

10. IF UNDER 1 YEAR

Months
22

IF UNDER 24 HRS.

Days
0

Year
1960

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cantor

10b. KIND OF BUSINESS OR INDUSTRY

plastic co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Gross

14. MOTHER'S MAIDEN NAME

Alberta Bladen

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or date of service)

Korean War

16. SOCIAL SECURITY NO.

216 32 0915

17. INFORMANT

Elizabeth B. Gross, 47 cottage ch. service

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning

850 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. }
(b)

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPSY
PERFORMED?

YES NO

2
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell overboard

20c. TIME OF INJURY
Hour 10:00 p.m.
6/4 1960

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)
Annapolis Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Russell S. Fisher

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
6/6/60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial 6-10-60

22c. NAME OF CEMETERY OR CREMATORI

Anna. Natl.

22d. LOCATION (City, town, or county)
(State)

Annapolis Md.

23. FUNERAL DIRECTOR

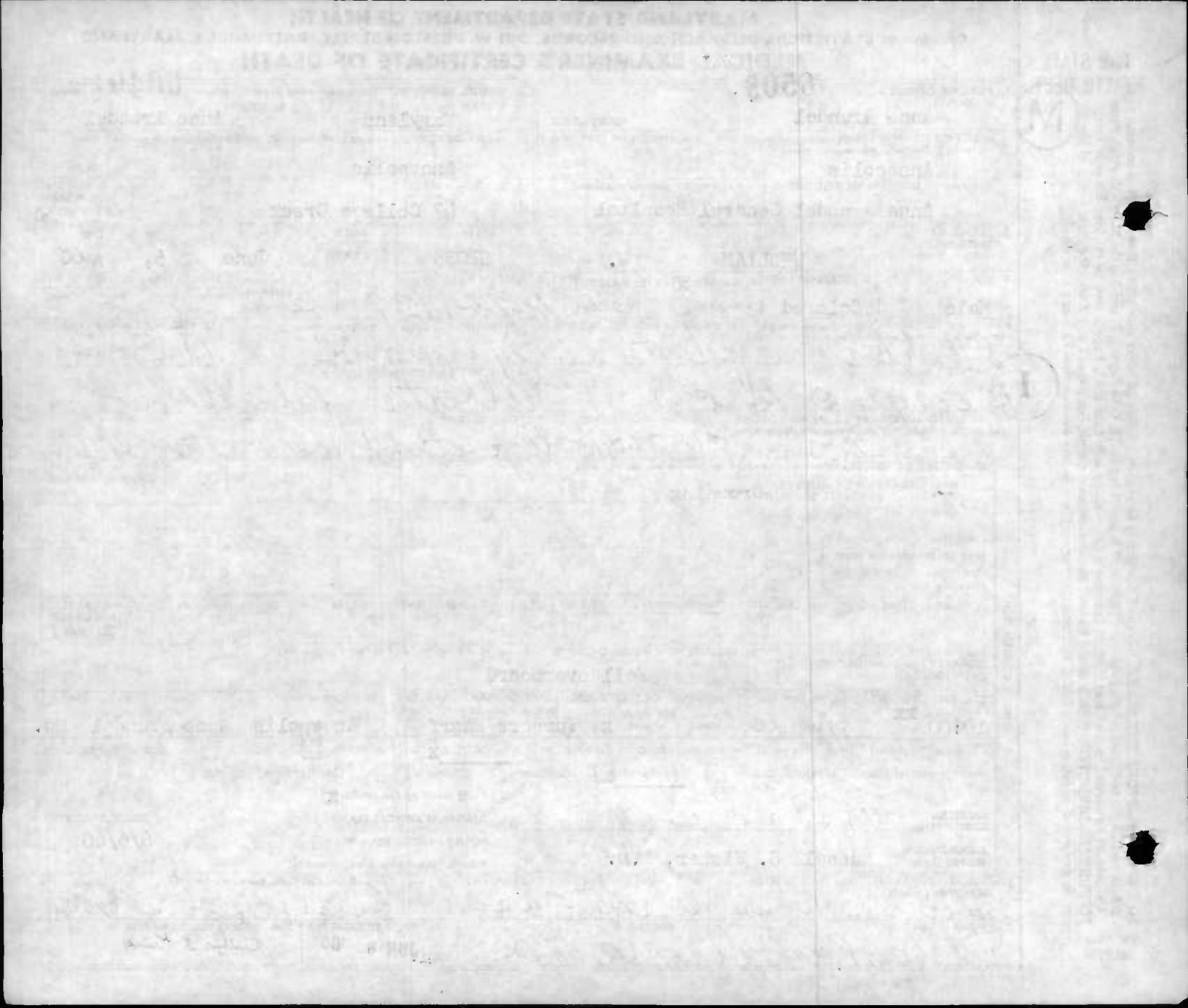
ADDRESS

William Reese # Anna Md

24a. REC'D BY REGISTRAR

Arthur S. Krause

DATE JUN 8 '60



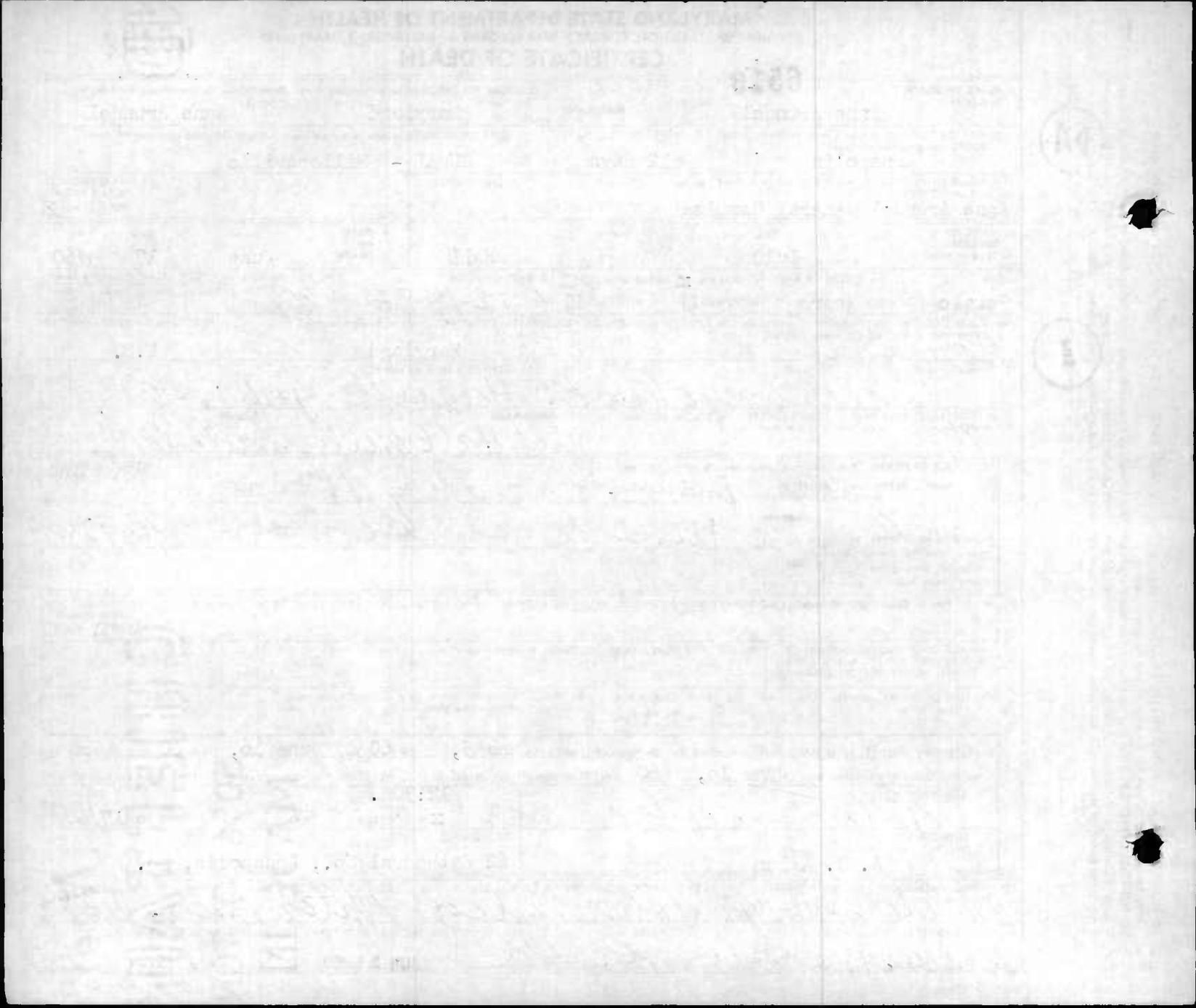
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06492

1. PLACE OF DEATH a. COUNTY		6510 Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Annapolis 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Millersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Anne Arundel General Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Lulu	Middle 	Last HALL	4. DATE OF DEATH June 17	Month Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6-12-1886	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Jedrick Johnson		14. MOTHER'S MAIDEN NAME Harriet Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Lee Hall Millersville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Diabetes mellitus		Pneumonia + Lung abscess		INTERVAL BETWEEN ONSET AND DEATH start with	
(c)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1960, to June 16, 1960, that (I) (we) last saw the deceased alive on June 16, 1960, and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE A. T. Allen		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/17/60		
22c. PHYSICIAN'S NAME (Type) A. T. Allen		22d. ADDRESS 62 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-1960		23c. NAME OF CEMETERY OR CREMATORIAL John Wesley Waterbury Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reesett Anna Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 21 '60	
				25b. REGISTRAR'S SIGNATURE C. Lee S. Evans	



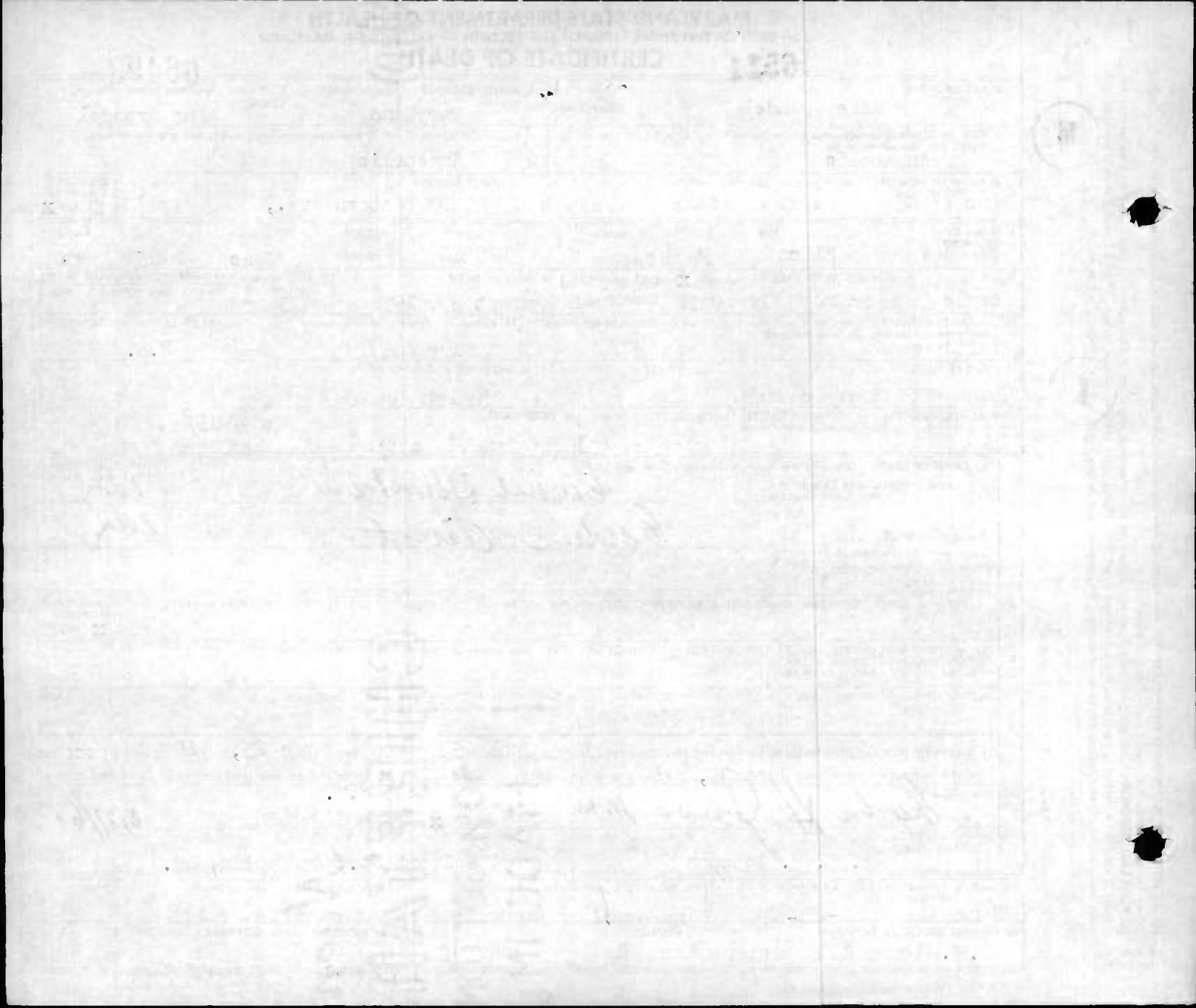
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6511

CERTIFICATE OF DEATH

06493

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ellen	Middle Felecia	Last HARRIS
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John William Powell		14. MOTHER'S MAIDEN NAME Helen Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-8751	
17. INFORMANT Reginald Harris		Address Annapolis, Md 203 Eastern Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 432-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1960 , to June 25, 1960 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on June 25, 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Theresa H. Johnson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10:55 P.M.	
22c. PHYSICIAN'S NAME (Type) Dr. T. H. Johnson		22d. ADDRESS 37 Calvert St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-29-60	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Annapolis Neck		23d. LOCATION (City, town, or county) (State) Annapolis, Md	
24. FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks 111 Annapolis Md		25a. REC'D BY REGISTRAR DATE JUN 29 1960	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hicks	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

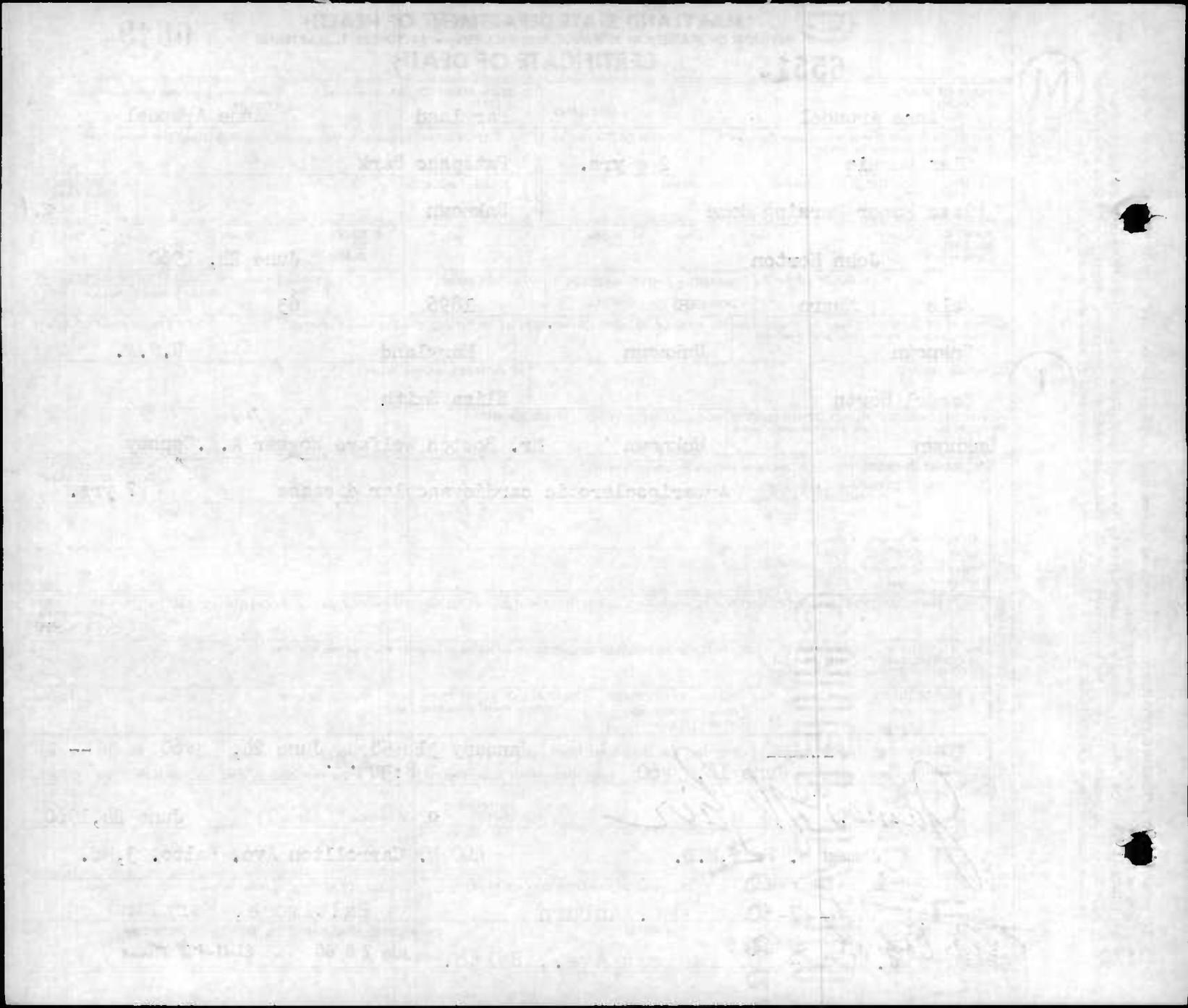
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06494

6551

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 ½ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Patapsco Park		d. STREET ADDRESS Unknown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Horton		First	Middle	Last	4. DATE OF DEATH June 24, 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1896	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Hortn				14. MOTHER'S MAIDEN NAME Eliza Smith				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Boston Welfare Worker A.A.County		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.01</i>		Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH ? yrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
January 31, 1958 19								
21. I certify that (I) (<u>this hospital</u>) attended the deceased from January 31, 1958 to June 24, 1960, that (I) (we) last saw the deceased alive on June 18, 1960, and that death occurred at 8:30 A.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>James M. Pair</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 24, 1960	
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.				22d. ADDRESS 400 N. Carrollton Ave. Balto. 23, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-27-60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Auburn		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>						25a. REC'D BY REGISTRAR DATE JUN 28 '60		
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6512

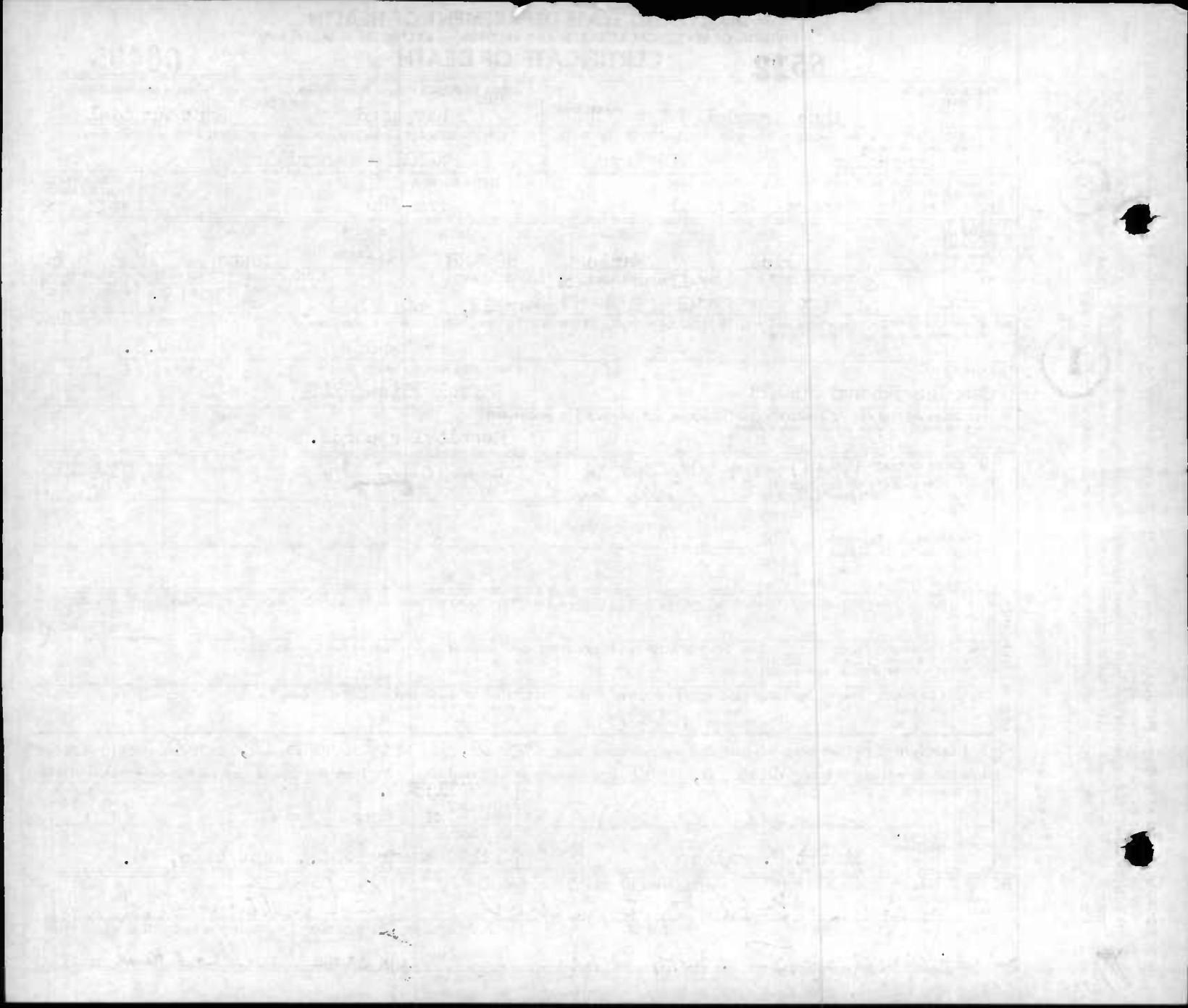
CERTIFICATE OF DEATH

06495

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Annapolis		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Anne Arundel	
3. NAME OF DECEASED (Type or print) Alice		First Marie	Middle HOWARD
4. DATE OF DEATH June 17		Month Day Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1960
9. AGE (In years lost birthday) yrs. 19		10. IF UNDER 1 YEAR Months 19	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Edward HOWARD		14. MOTHER'S MAIDEN NAME Hazel Alice BELT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 19 days (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 29, 1960, to June 16, 1960, that (I) (we) lost saw the deceased alive on June 16, 1960, and that death occurred at M, from the causes and on the date stated above.		21. DATE 11:50A.	
22a. SIGNATURE Stuart H. Walker		22b. DATE SIGNED 17 June '60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-18-60	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor		23d. LOCATION (City, town, or county) Chesterfield, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Annap. Md.		25a. REC'D BY REGISTRAR DATE JUN 21 '60	
ADDRESS 206 31355 X VO		25b. REGISTRAR'S SIGNATURE John & Anna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to gain papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



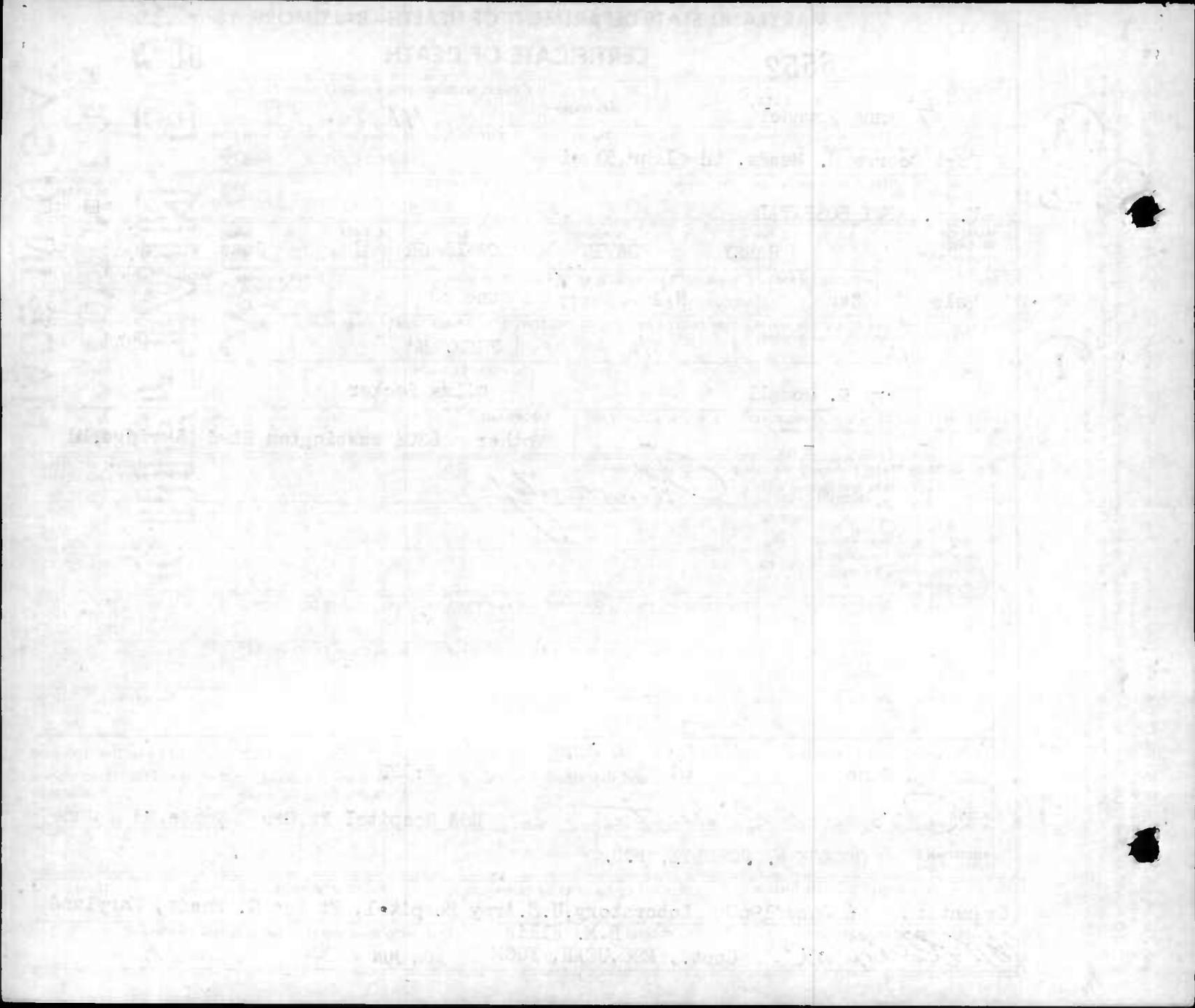
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06496
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Fort George G. Meade, Md 1 hr 50 mi		b. COUNTY		Howard				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		U. S. ARMY HOSPITAL		d. STREET ADDRESS		Elkridge 6804 Washington Blvd.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First HARRY	Middle DAVID	Last HOWELL JR	4. DATE OF DEATH	Month June	Day 4	Year 60		
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 60		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months 1		IF UNDER 24 HRS. Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) FGGM, Md		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Harry D. Howell				14. MOTHER'S MAIDEN NAME Wilma Becker						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Mother		Address 6804 Washington Blvd Elkridge, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } lying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Day 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 4 June 1960 to 4 June 1960, that I last saw the deceased alive on 4 June 1960, and that death occurred at 8:22A, from the causes and on the date stated above.										
ADDRESS (Street, city or town, state)										
DATE SIGNED										
ACTUAL SIGNATURE George N. Schultz		M.D. USA Hospital Ft Geo G Meade, Md 4 June 60-								
PHYSICIAN'S NAME (Type)		GEORGE N. SCHULTZ, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6 June 1960		22c. NAME OF CEMETERY OR CREMATORIUM Laboratory, U.S. Army Hospital		22d. LOCATION (City, town, or county) Ft Geo G. Meade, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE John E. Schatz, Jr. Capt., MSC, USAH, FGGM		ADDRESS B.M. Ellis		24a. REC'D BY REGISTRAR DATE JUN 9 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline				

2050254 XV 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event.

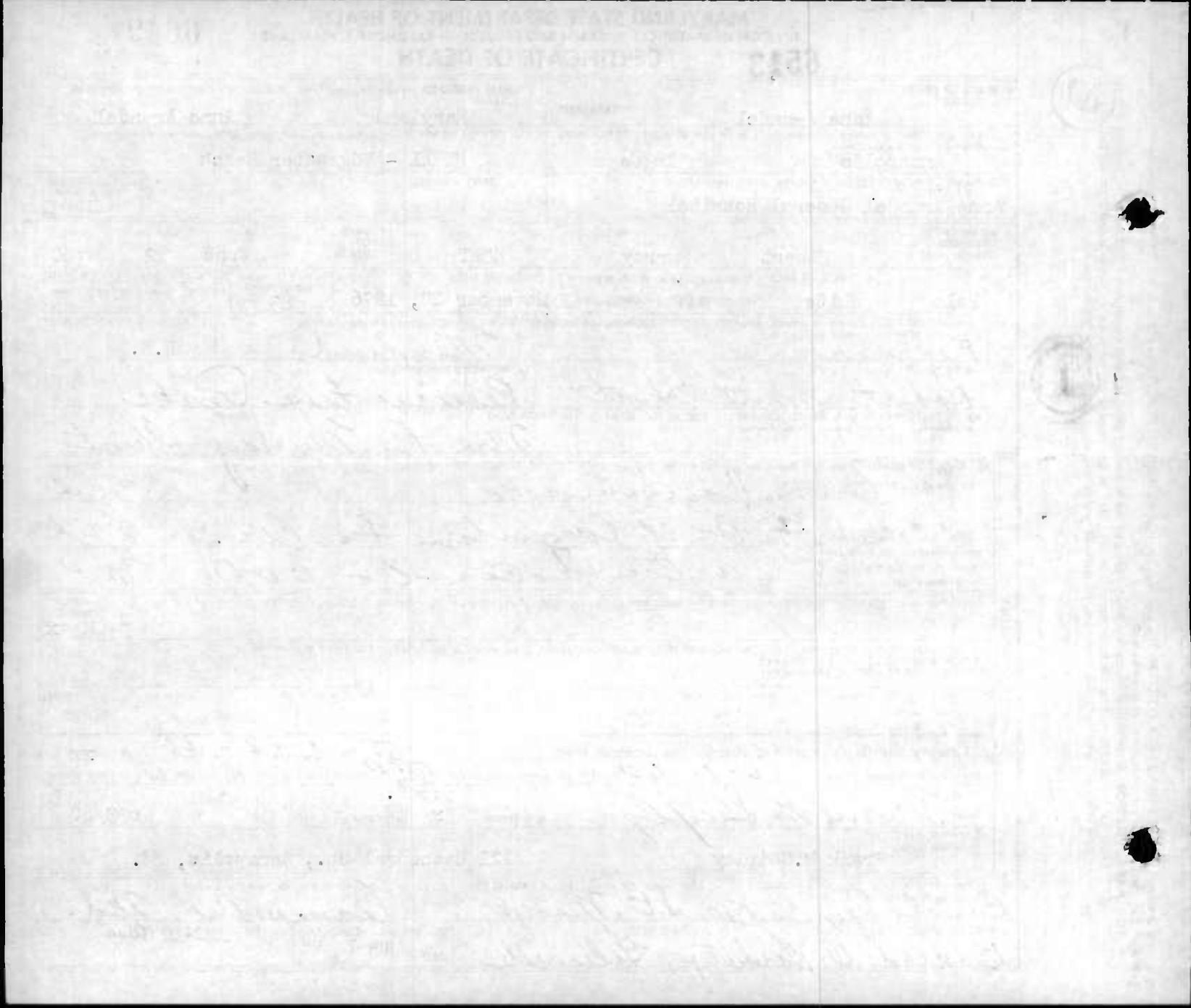
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06497

6513

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater Beach				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert		First Murray	Middle HUNT	Last HUNT	4. DATE OF DEATH June 2 1960	Month June	Day 2	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1876		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Robert Smith Hunt		14. MOTHER'S MAIDEN NAME Rebecca Faye Peake				Address Mrs. R. Murray Hunt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c)		
						Pneumonia Acute Congestive Failure and cerebral edema		
19. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 3 hr.		
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
		21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		1955 to 6-2-60		22b. DATE SIGNED 6/3/60		
		22a. SIGNATURE Frank M. Shipley		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
		22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 6, 1960		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		23d. LOCATION (City, town, or county) Annapolis		(State) Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Bernard J. Hardisty, Bel Air		ADDRESS ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 7 '60		25b. REGISTRAR'S SIGNATURE Signature		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5553

CERTIFICATE OF DEATH

Reg. Dist. No.

06498

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Hill</i>		b. COUNTY <i>Anne Arundel</i>	
c. LENGTH OF STAY IN 1b <i>15 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton, P. O.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>108 Central Ave.</i>		d. STREET ADDRESS <i>Odenton, Md.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Marvin S. Jeffrey</i>		First <i>S.</i>	Middle <i>Jeffrey</i>
4. DATE OF DEATH <i>June 27 1960</i>		Month <i>June</i>	Day <i>27</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Feb. 11-1904</i>		9. AGE (In years last birthday) <i>56 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>(Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A.A.C. Police Dept.</i>	11. BIRTHPLACE (State or foreign country) <i>A.A.C., Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>George S. Jeffrey (dec.)</i>		14. MOTHER'S MAIDEN NAME <i>Annie Wade (dec.)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-38-0342</i>	
17. INFORMANT <i>Singleton Jeffrey - 1223 Southview Rd, Balt., Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
		Cause of Death <i>Coronary thrombosis</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>2nd</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan.</i> , 19 <i>50</i> , to <i>Jun. 27</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jun. 27</i> , 19 <i>60</i> , and that death occurred at <i>108 Central Ave.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jean S. Bellengher</i> M.D. ADDRESS (Street, city or town, state) <i>108 Central Ave. Glen Burnie, Md.</i> DATE SIGNED <i>Jun. 27, 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-29-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Epiphany Epiphany Cemetery, Odenton</i>
22d. LOCATION (City, town, or county) (State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Singleton Funeral Home - Robert P. Currie</i>		24a. REC'D BY REGISTRAR DATE JUN 30 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knue</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06499

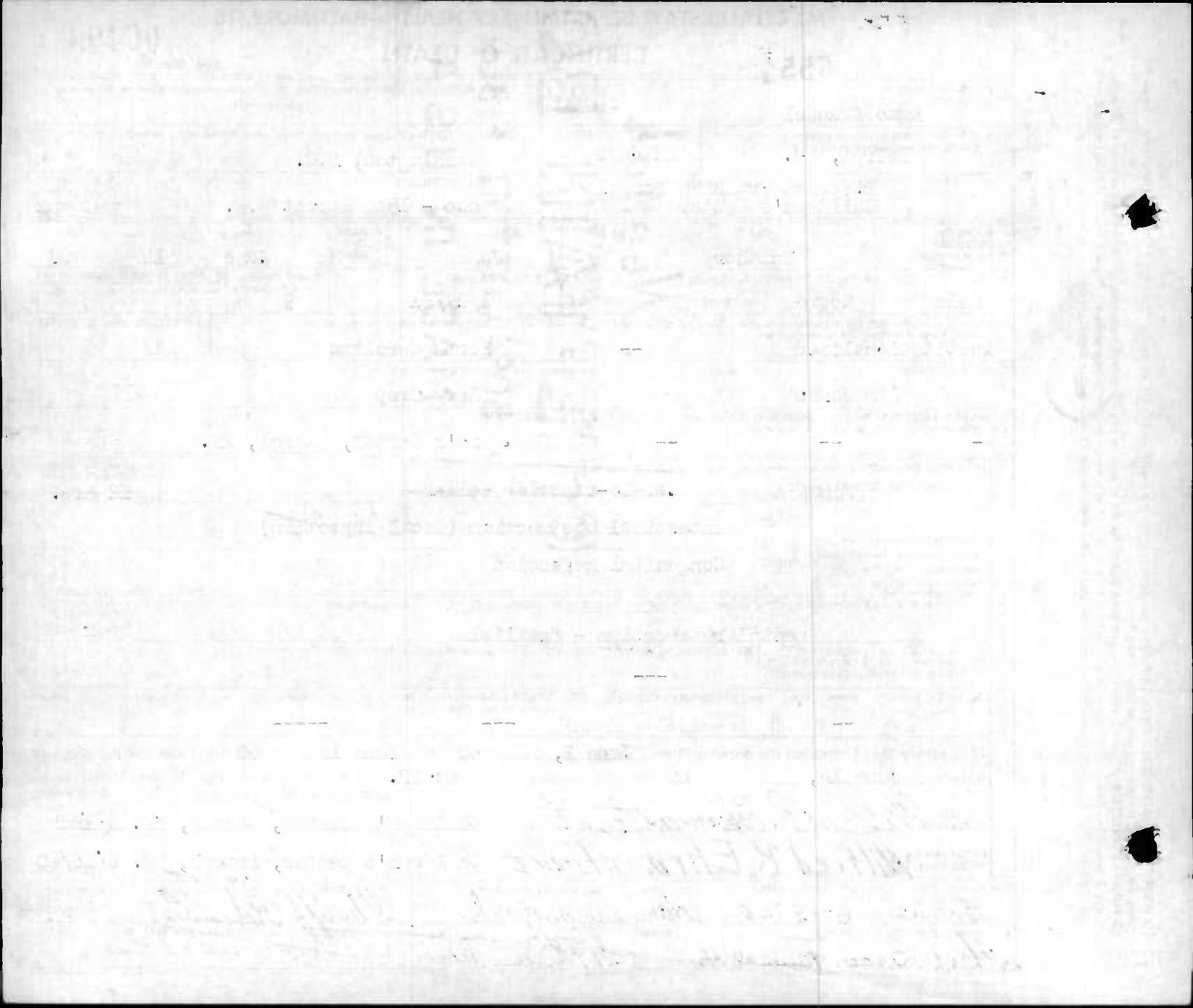
Reg. Dist. No.

6554

CERTIFICATE OF DEATH

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN 1b 12 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.				
d. STREET ADDRESS 606 - 15th Street N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Keither	Middle	Last Jones			
4. DATE OF DEATH	Month June	Day 14	Year 1960			
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/29/51			
9. AGE (In years last birthday) 9 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) institutionalized	11. KIND OF BUSINESS OR INDUSTRY ---	12. BIRTHPLACE (State or foreign country) North Carolina			
13. FATHER'S NAME Jim Jones	14. MOTHER'S MAIDEN NAME Mary Gray					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---	16. SOCIAL SECURITY NO. ---	INFORMANT Children's Center, Laurel, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Intestinal obstruction (fecal impaction)						
(c) Congenital megacolon						
INTERVAL BETWEEN ONSET AND DEATH 12 hrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) mental retardation - familial						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---				
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County) ---	(State) ---
21. I certify that I attended the deceased from June 2, 1960 , to June 14, 1960 , that I last saw the deceased alive on June 14, 1960 , and that death occurred at 8:00P.M. , from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) Wilfred R. Ehmantrout, M.D. Children's Center, Laurel, Md. 6/16/60						
DATE SIGNED Wilfred R. Ehmantrout, M.D. Children's Center, Laurel, Md. 6/16/60						
ACTUAL SIGNATURE Wilfred R. Ehmantrout		PHYSICIAN'S NAME (Type) Wilfred R. Ehmantrout Children's Center, Laurel, Md. 6/16/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-18-60	22c. NAME OF CEMETERY OR CREMATORIUM Harmont Park	22d. LOCATION (City, town, or county) (State) Sheriff Rd. St. Arthur S. Trahan		
23. FUNERAL DIRECTOR'S SIGNATURE Stetl Bros. Funeral Home 6217 La. Ave. N.E.		ADDRESS ---	24a. REC'D BY REGISTRAR DATE JUN 20 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 06560					
Item 4 Film G266 7-5-60 et																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>				c. LENGTH OF STAY IN 1b <i>5 yrs.</i>				b. COUNTY <i>Greenland</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>H-3-Divisional Hwy (Green Haven)</i>				e. STREET ADDRESS <i>H-3-Divisional Hwy. (Green Haven)</i>				d. STREET ADDRESS <i>H-3-Divisional Hwy. (Green Haven)</i>									
3. NAME OF DECEASED (Type or print)		First <i>John</i>		Middle <i>S.</i>		Last <i>Tubb</i>		DATE OF DEATH <i>11 Jun 1896</i>		Month <i>June</i>		Day <i>21</i>		Year <i>1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11 Jun 1896</i>		9. AGE (In years last birthday) <i>67 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Days <i>0</i>		Hours <i>0</i>		Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sept. (ret.)</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Gas Elec. Co.</i>				11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Joseph Tubb</i>				14. MOTHER'S MAIDEN NAME <i>(unknown) Leidner</i>				Address									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>212056554</i>				17. INFORMANT <i>Mrs. Elizabeth C. Tubb Sanatorium</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1-year</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i> DUE TO <i>Carcinoma of the stomach</i>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>June 20, 1960</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore Nat'l. Cemetery</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Md.</i>		(State) <i>Md.</i>					
21. I certify that I attended the deceased from <i>June 7, 1960</i> , to <i>June 21, 1960</i> , that I last saw the deceased alive on <i>June 20, 1960</i> , and that death occurred at <i>6:00 PM</i> , from the causes and on the date stated above.																	
ACTUAL SIGNATURE <i>R. M. McLaughlin</i> ADDRESS (Street, city or town, state) <i>Pasadena, Md.</i> DATE SIGNED <i>June 21, 1960</i>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>24 June 1960</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat'l. Cemetery</i>				22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. E. Drington</i>				ADDRESS <i>Glen Burnie, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 27 '60</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

21-352-MJF14G-18724W 30 JULY 2018 BY 350 STATE OF WASH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

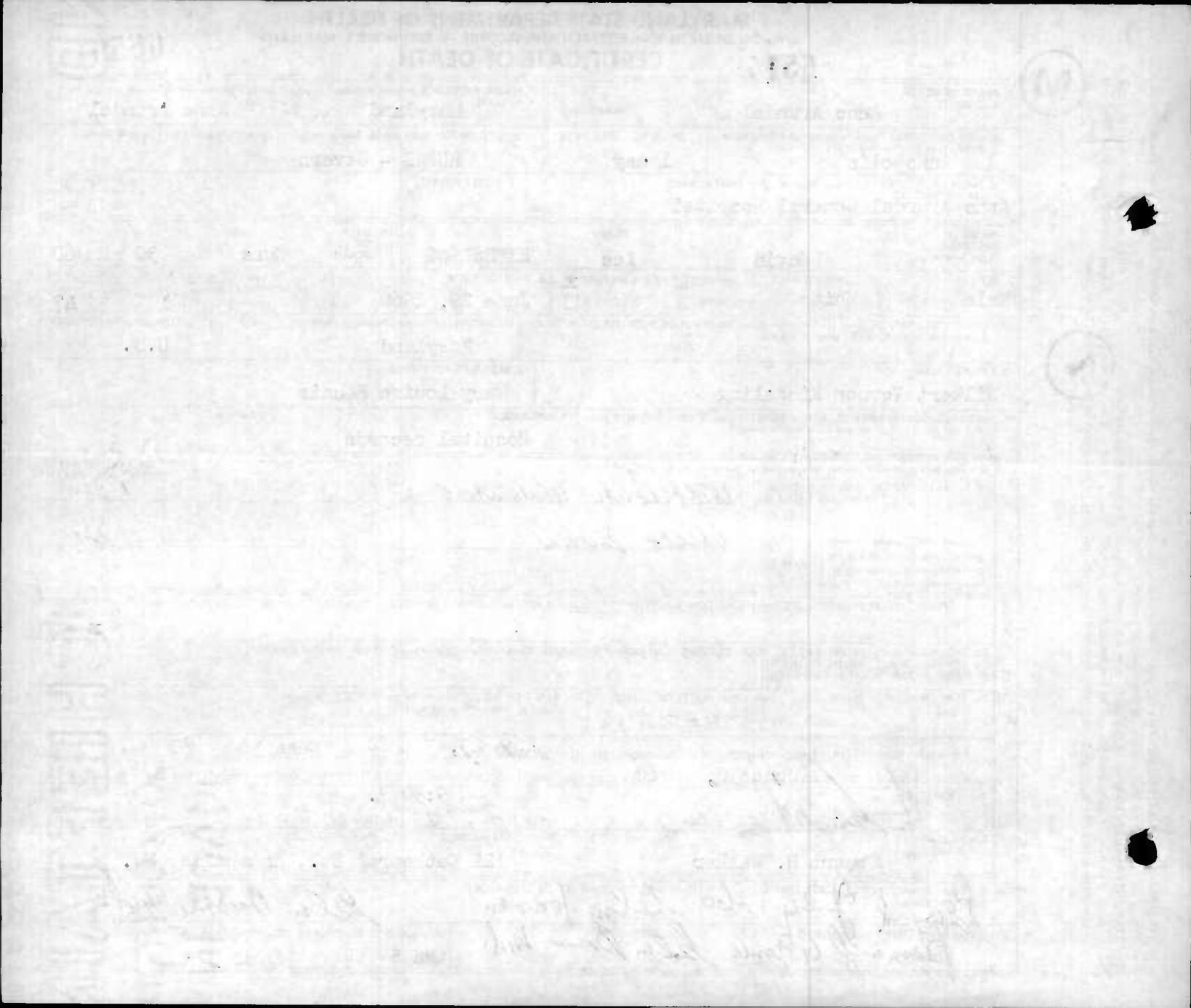
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6514

CERTIFICATE OF DEATH

065011

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Severn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital						d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First David	Middle Lee	Last KIESSLING	4. DATE OF DEATH June 29, 1960	Month June	Day 30	Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 29, 1960	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 47	Hours 1	Min. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Wilbert Vernon Kiessling			14. MOTHER'S MAIDEN NAME Mary Louise Rahnis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BLEECH DELIVERY DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from June 29, 1960, to June 30, 1960, that (I) (we) last saw the deceased alive on June 30, 1960, and that death occurred at M, from the causes and on the date stated above.		9:30 P.						22b. DATE SIGNED	
22a. SIGNATURE Stuart H. Walker		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1-60		23c. NAME OF CEMETERY OR CREMATORIAL Beth Haven		23d. LOCATION (City, town, or county) Beth Haven Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard G. Knoll		ADDRESS Beth Haven Md.		25a. REC'D BY REGISTRAR Date 5 '60		25b. REGISTRAR'S SIGNATURE Clyde S. Evans			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G-268 8/5/60.c.

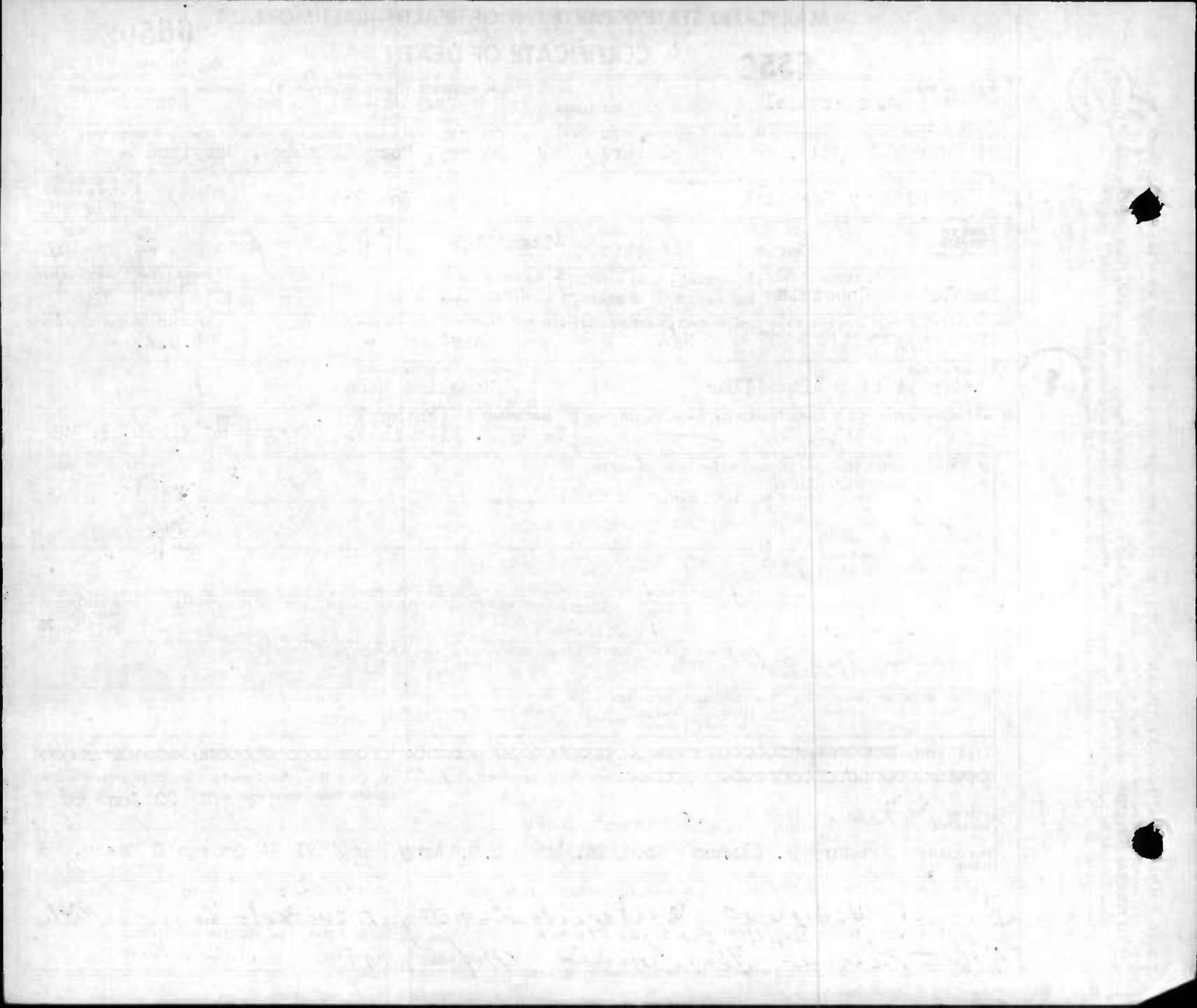
06502

6556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G Meade, Md		c. LENGTH OF STAY IN lb 18 Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle Annette Last Kitzmiller		4. DATE OF DEATH Month June Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1960
9. AGE (In years last birthday) yrs. 18	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	11. KIND OF BUSINESS OR INDUSTRY N/A	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Teddy William Kitzmiller	14. MOTHER'S MAIDEN NAME Madeline Kane	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ____	
16. SOCIAL SECURITY NO. _____		INFORMANT (Father) Teddy W. Kitzmiller	Address Dorsey Rd Elkridge, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 18 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that the deceased died on _____ and that death occurred at 6:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 22 June 60 DATE SIGNED			
ACTUAL SIGNATURE <u>Henry N. Claman</u> M.D. PHYSICIAN'S NAME (Type) Henry N. Claman Captain, MC U.S. Army Hospital Ft George G Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 23 June 60	22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery	22d. LOCATION (City, town, or county) (State) Howard Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Claman</u>	ADDRESS (Street, city or town) <u>Glen Burnie, Md</u>	24a. REC'D BY REGISTRAR DATE JUN 27 '60	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

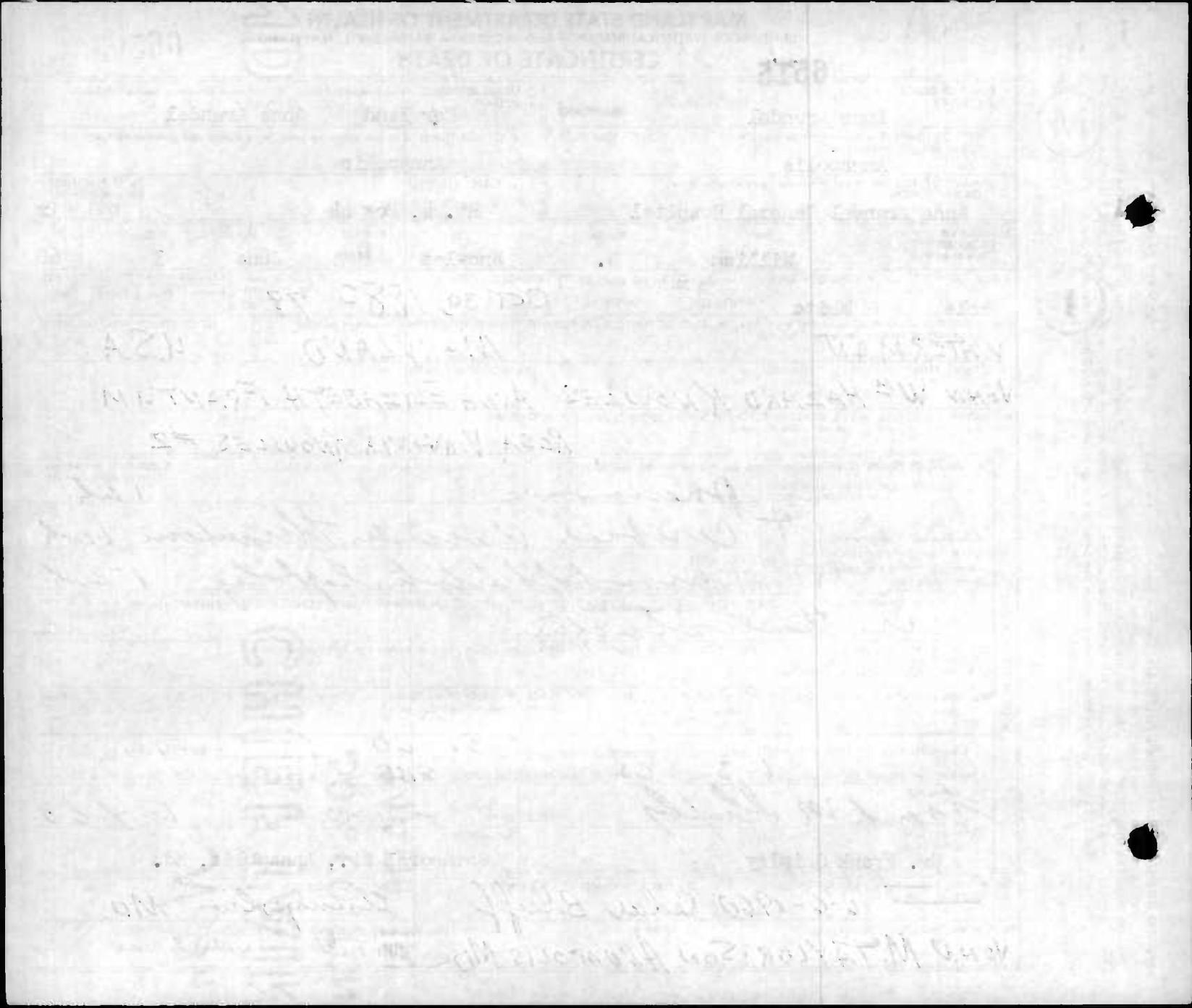
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06563

6515

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Rt. 4, Box 44		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William H. Knowles		First	Middle	Last	4. DATE OF DEATH June 3 1960	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCT 30, 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN W^M HAZARD KNOWLES		14. MOTHER'S MAIDEN NAME ANNA ELIZABETH FRANTUM						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Rosa Virginia Knowles #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia INTERVAL BETWEEN ONSET AND DEATH 1 wk								
463 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) Cerebral Vascular thrombosis 1 wk cause (c), stating the under- (c) thromboembolism, left leg 1 wk								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) urinary stasis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-31-60 to 6-3-60 that (I) (we) last saw the deceased alive on 6-3-1960 and that death occurred at ESPA , from the causes and on the date stated above.		22b. DATE SIGNED 6-4-60						
22a. SIGNATURE Frank M. Shipley		M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Dr. Frank Shipley		22d. ADDRESS Cathedral St., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-6-1960		23b. DATE THEREOF 6-6-1960		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Bluff		23d. LOCATION (City, town, or county) (State) Annapolis Mo.		
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Son Annapolis Mo		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
<i>Boat Bay</i>								



TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

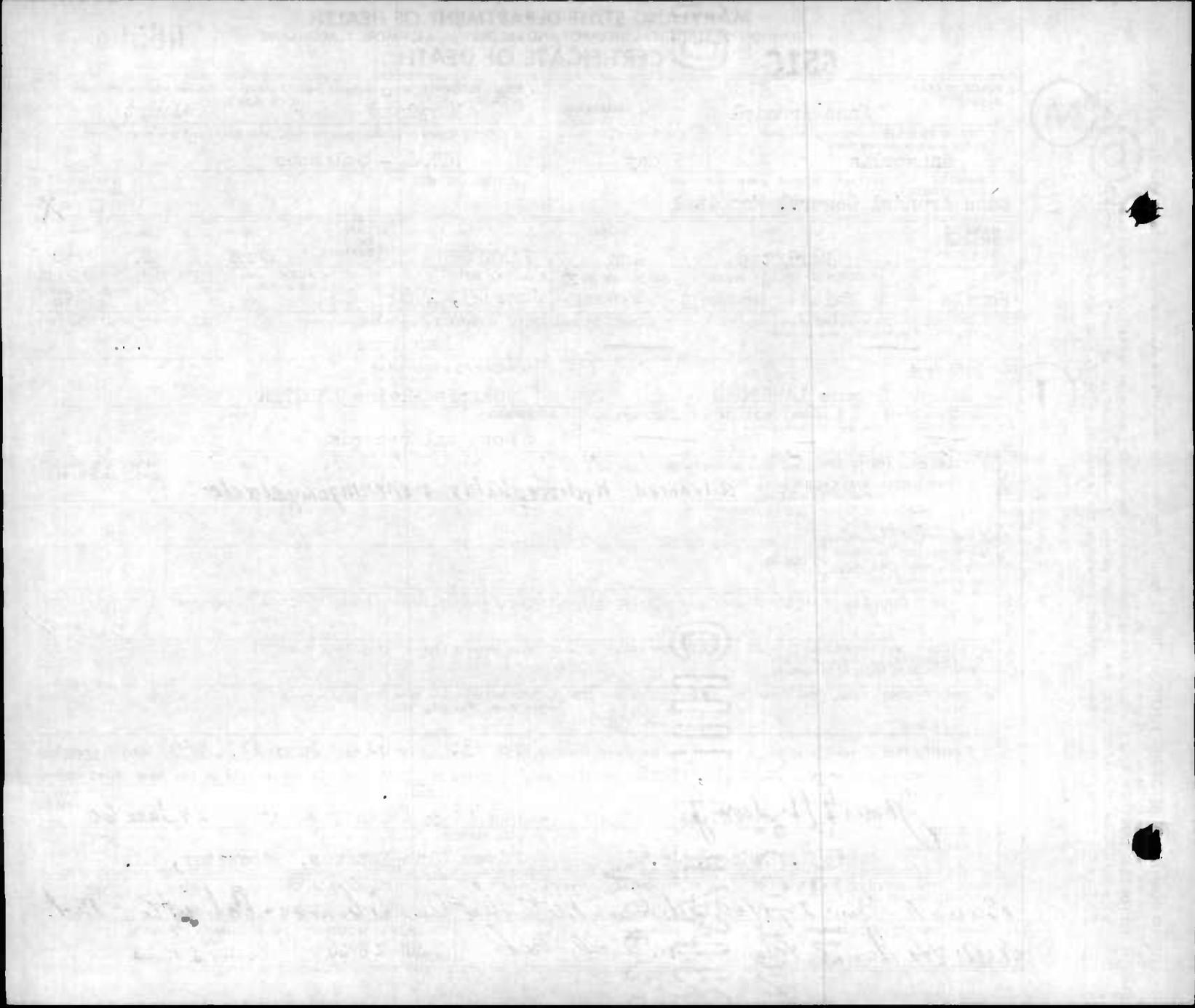
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06504

6516

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Anne Arundel MARYLAND		a. STATE Maryland	b. COUNTY Calvert
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Solomons	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Charlotte	Middle Ann
Last LANKFORD		4. DATE OF DEATH	Month June
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	Day 24
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Year 1960
8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
June 23, 1960		Months 1	Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
		Maryland	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Roland Eugene LANKFORD		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Advanced hydrocephalus + Meningomyelcele	
752X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO	
{ (b)		DUE TO	
{ (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 23, 1960, to June 23, 1960, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on June 23, 1960, and that death occurred at M, from the causes and on the date stated above.		2:20A.	
22a. SIGNATURE		22b. DATE SIGNED	
James I. Hudson, Jr.		24 June 60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
James I. Hudson, Jr.		River Club Estates, Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial June 25, 1960		23c. NAME OF CEMETERY OR CREMATORIUM	
24. FUNERAL DIRECTOR'S SIGNATURE		23d. LOCATION (City, town, or county) (State)	
A. A. Valentine & Son - Mutual, Md.		Solomons Methodist Cem. Charles - Calvert - Ind.	
ADDRESS		25a. REC'D BY REGISTRAR	
		DATE JUN 28 '60	
		25b. REGISTRAR'S SIGNATURE	
		Arthur S. Kraus	



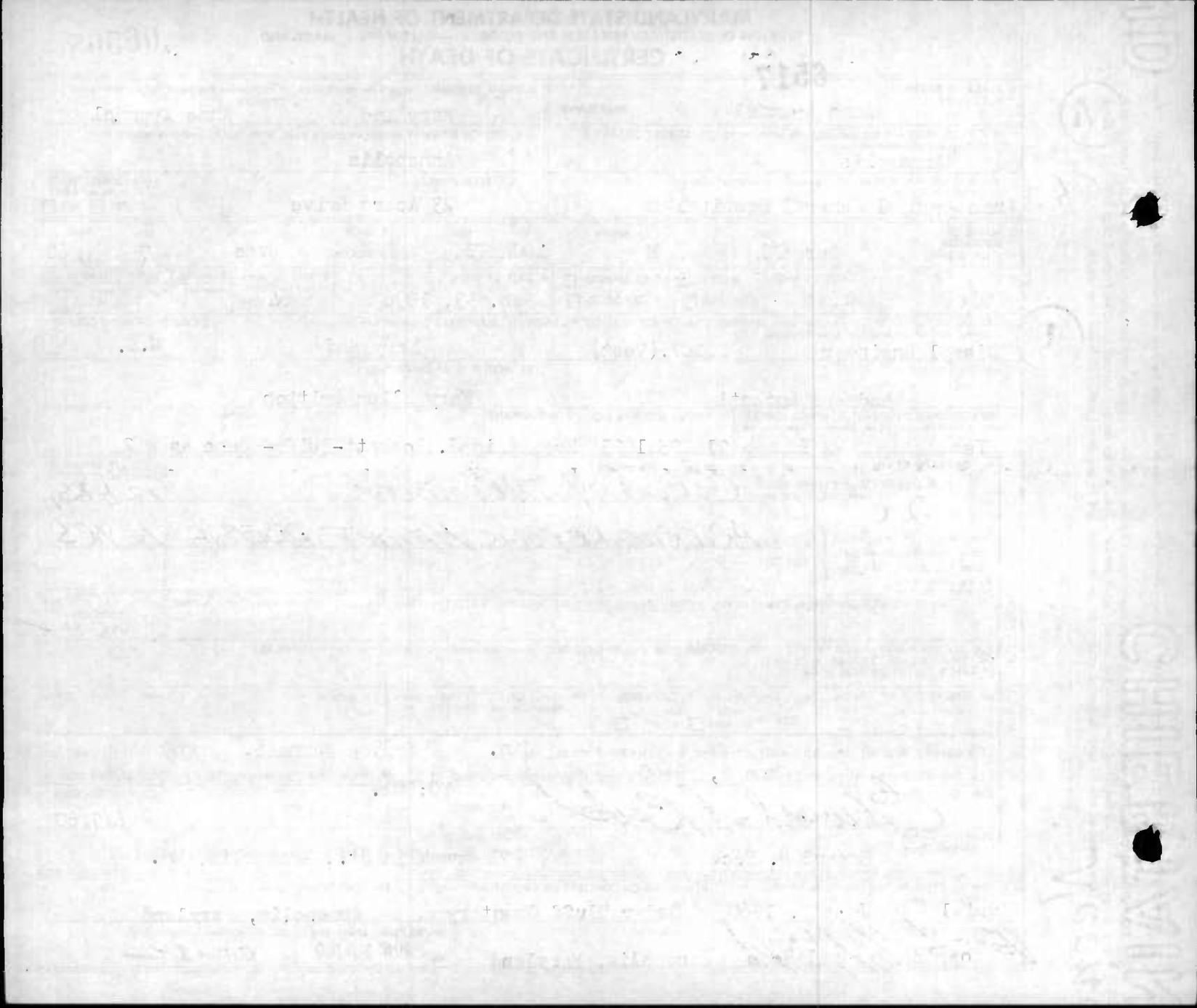
TO HOSPITAL may be referred by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06505

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Russell	Middle M	Last LOCKETT
4. DATE OF DEATH	Month June	Day 7	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1896
9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months /	11. IF UNDER 24 HRS. Days 23 Acorn Drive	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diesel Engineer		10b. KIND OF BUSINESS OR INDUSTRY USGOV. (Test)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thaddeus Lockett		14. MOTHER'S MAIDEN NAME Mary Ellen Britton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 214 05 0023	
17. INFORMANT Mrs Annie J. Lockett - Wife - Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 12 HRS.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO ARTERIOESCLEROTIC HEART DISEASE 10 YRS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 19 59 to June 6, 19 60, that (I) (we) last saw the deceased alive on June 6, 19 60, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE Edward S. Beck	
		22b. DATE SIGNED 10:50A. 6/7/60	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS 71 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9, 1960	
		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Bluff Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		23d. LOCATION (City, town, or county) Annapolis, Maryland	
		25a. REC'D BY REGISTRAR DATE JUN 10 '60	
		25b. REGISTRAR'S SIGNATURE Cathleen S. Krause	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06506

6557

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25 Maryland	
3. NAME OF DECEASED (Type or print) Thomas		4. DATE OF DEATH Month June Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dock hand		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Luster		14. MOTHER'S MAIDEN NAME Ida Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Leo Boston-A.A.Co. D.P.W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 to June 7, 1960 that (I) (we) last saw the deceased alive on June 5, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James M. Pair		22b. DATE SIGNED June 8, 1960	
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 400 N. Carrollton Ave. Balto. 23, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-60	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
25a. REC'D BY REGISTRAR JUN 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

20

27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6518

CERTIFICATE OF DEATH

66567

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md.</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>		c. LENGTH OF STAY IN 1b <i>20 ft</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena RFD - Ventnor</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>		d. STREET ADDRESS <i>Rt. 1 - Box 113 B</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Anna</i>		First <i>F.</i>	Middle <i></i>	Last <i>Marshall</i>	4. DATE OF DEATH <i>June 2, 1960</i>	Month <i>June</i>	Day <i>2</i>	Year <i>1960</i>	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7 April 1875</i>	9. AGE (In years lost birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (etc.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Neithaus</i>		14. MOTHER'S MAIDEN NAME <i>Frances Bellhorn</i>		Address <i>Same as #2</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Mrs. Lenore F. Inman</i>		INTERVAL BETWEEN ONSET AND DEATH <i>one hour</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i>		DUE TO <i>450.1</i>		DUE TO <i>Arteriosclerotic Cardiovascular Disease</i>		3 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Generalized Arteriosclerosis</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>March 1960</i> , to <i>June 2, 1960</i> , that I last saw the deceased alive on <i>May 27, 1960</i> , and that death occurred at <i>3:29 PM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Arthur Lankford Jr.</i> M.D. <i>Mountain Rd. #8</i>									
PHYSICIAN'S NAME (Type) <i>ARTHUR LANKFORD JR.</i> ADDRESS <i>Pasadena, Maryland</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6 June 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Lorraine Park Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Y. Livingston</i>		ADDRESS <i>Glen Burnie Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 EROMIN—HUMAN TO IMMUNOGLOBULIN

THIS IS A PERMANENT RECORD.
EVERY INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

M
X
I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6558

CERTIFICATE OF DEATH

2. DATE OF DEATH

06568
6-15-68

1. NAME OF DECEASED
(Type or Print)

ELLA MILLER

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

Dwight Elementary School
(If not in hospital or institution, give street
address or location)

FULL NAME OF
HOSPITAL OR
INSTITUTION

5931 BELLE GROVE Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND A.A. County

C. CITY OR TOWN

50 BALTIMORE - 25

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

15931 BELLE GROVE Rd. (If rural, give location)

S. SEX

6. COLOR OR RACE

F

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

8-3-1877

9. AGE (In years
last birthday)

82

If Under 1 Year

Months

If Under 24 Hours

Days

Hours

Min.

10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SPENCER PATRICK

14. MOTHER'S MAIDEN NAME

BETTY FITZGERALD

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

VIOLA MILLER 5931
BELLE GROVE Rd.

ADDRESS

L CERTIFICATION

1B.

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)
DUE TO

MYOCARDIAL INFARCTION

(B)
DUE TO

ARTERIOSCLEROTIC
CARDIOVASCULAR DIS.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II
21D. TIME (Month) (Day) (Year)
OF INJURY

19A. DATE OF OPERATION

(Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

19B. CONDITION FOR WHICH OPERATION
PERFORMED

21F. HOW DID INJURY OCCUR?

20. AUTOPSY?

YES NO

22. I certify that (I) (this hospital) attended the deceased from

JUNE 15 1960

that (I) (we) last saw the deceased alive on

and that in (my) (our) opinion death occurred at

4:15

a.m.

from the causes and on the date stated above.

FEB. 9 1959 to
JUNE 6 1960

23A. SIGNATURE

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

23B. ADDRESS

922 S. Sharp

23C. DATE SIGNED

6/15/60

24A. BURIAL, CREMATION,
REMOVAL
(Specify)

24B. DATE

6-25-60

24C. NAME OF CEMETERY OR CREMATORIUM

ALTAVISTA Cem.

24D. LOCATION

(City, town, or county)

(State)

ALTAVISTA, VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.

JUN 17 1960

25B. NAME OF REGISTRAR

H. Williams

25C. FUNERAL DIRECTOR

Isaiah L. Brown & Son

ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06569

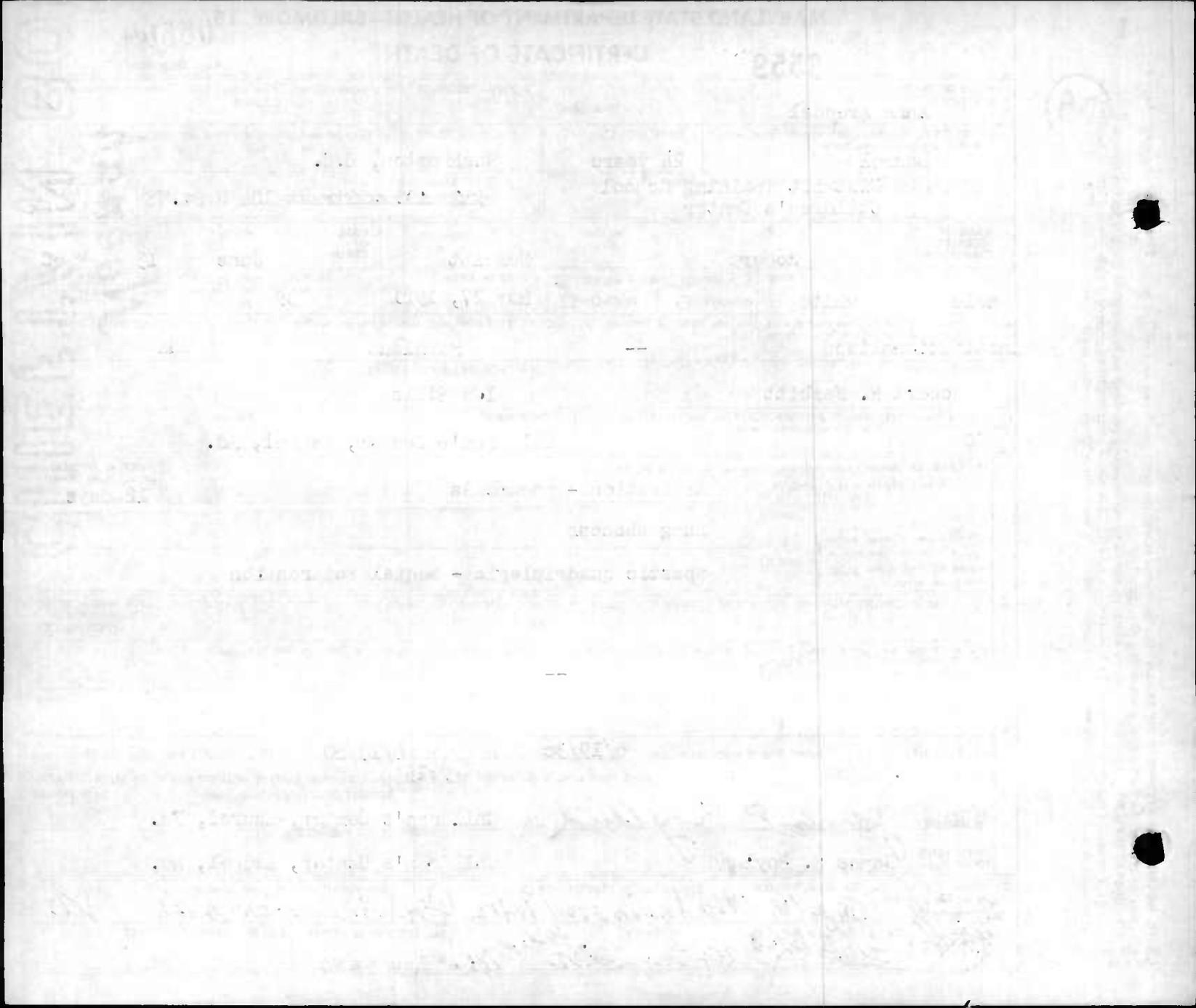
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 6912 Wisconsin Street 104 U St. NE		
d. NAME OF HOSPITAL (If deceased hospitalized, give address) OR INSTITUTION District Training School Children's Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last	4. DATE OF DEATH Nesbitt	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH May 27, 1921	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 39	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert H. Nesbitt		14. MOTHER'S MAIDEN NAME Ida Bills						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		INFORMANT		Address		
				Children's Center, Laurel, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Aspiration - pneumonia								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Lung abscess								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Spastic quadriplegia - mental retardation								
INTERVAL BETWEEN ONSET AND DEATH 12 days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) ---		(County) --- (State) ---
21. I certify that I attended the deceased from 6/19/36 , 19, to 6/13/60 , 19, that I last saw the deceased alive on 6/13/60 , 19, and that death occurred at 9:15 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) ---								
DATE SIGNED ---								
ACTUAL SIGNATURE <i>James E. Boyland</i>		M.D. Children's Center, Laurel, Md.						
PHYSICIAN'S NAME (Type) James E. Boyland		Children's Center, Laurel, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1960		22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATL CEM.		22d. LOCATION (City, town, or county) ARLINGTON NATL VI.		(State) VI.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Mallard</i>		ADDRESS 254 Carroll St. W.H. D.C.		24a. REC'D BY REGISTRAR ---		24b. REGISTRAR'S SIGNATURE Arthur Mallard		
				DATE JUN 16 '60				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6560

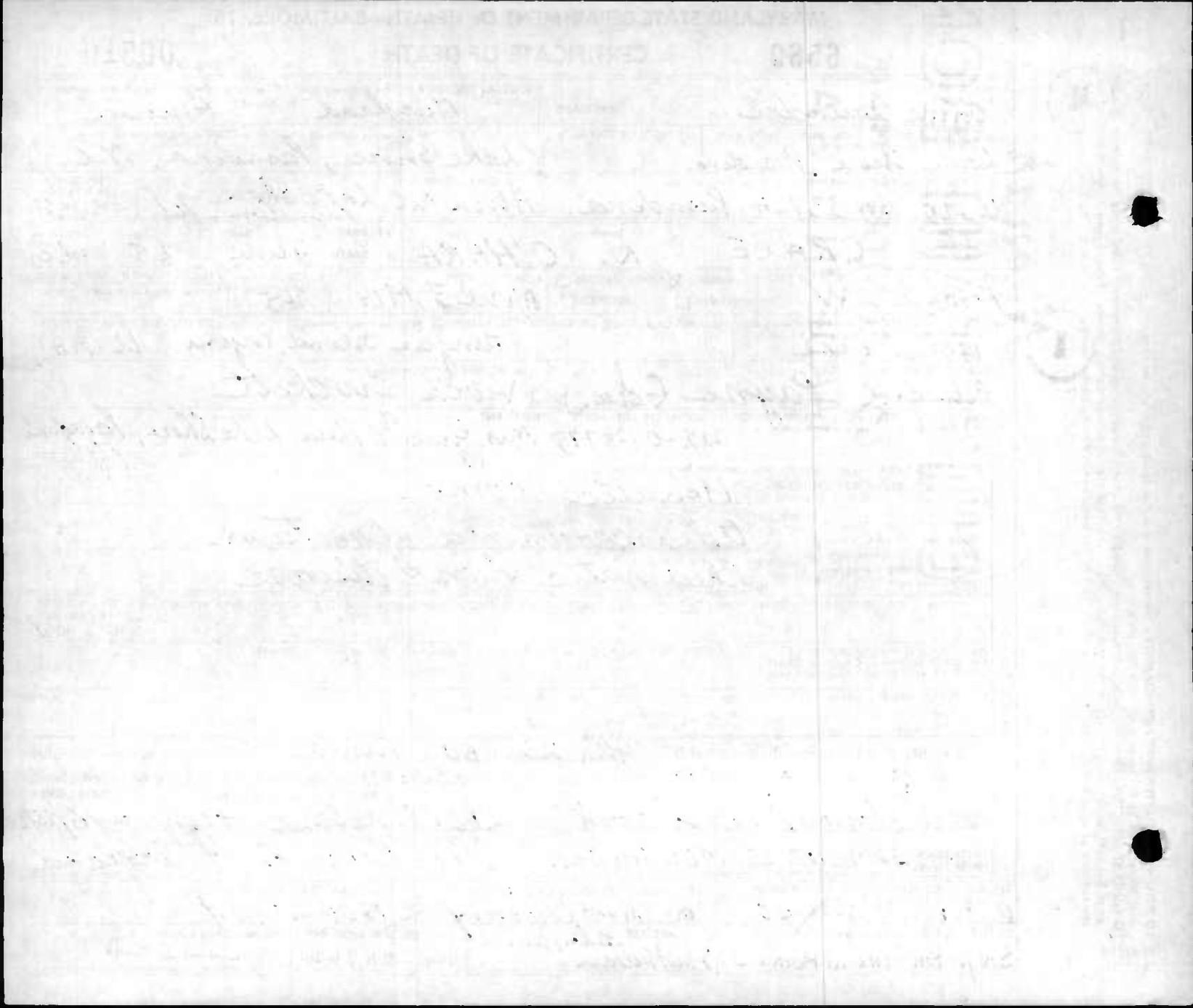
CERTIFICATE OF DEATH

06510
Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lake Shore, Pasadena</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lake Shore, Pasadena, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RE. 10 Box 337. A. Pasadena.</i>		e. STREET ADDRESS <i>Alvin Rd., Lake Shore, Pasadena, Md.</i>	
3. NAME OF DECEASED (Type or print) <i>GRACE</i>		First <i>R.</i>	Middle <i>O'HARA</i>
4. DATE OF DEATH <i>June 25 1960</i>		Last <i>45</i>	Month Day Year
S. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 3, 1914</i>
9. AGE (In years last birthday) <i>45 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) <i>Tanger Island, Virginia U.S.A.</i>
13. FATHER'S NAME <i>Edward Payne (dec.)</i>	14. MOTHER'S MAIDEN NAME <i>Viola Crockett</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>212-04-8777 Mrs. Grace O'Hara Lake Shore, Pasadena, Md.</i>	
16. SOCIAL SECURITY NO. <i>154X</i>		INFORMANT <i>Hepatic coma</i>	17. CITIZEN OF WHAT COUNTRY? <i>Address</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Odenocarcinoma of rectum</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic heart disease.</i>			
DUE TO (c) <i>154X</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>June 23, 1960, 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 23, 1960</i> , to <i>June 25, 1960</i> , that I last saw the deceased alive on <i>June 24, 1960</i> , and that death occurred at <i>3:55 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Edmond I. Moushabek M.D. 21015 Ritchie Highway 6/25/60</i>	
ACTUAL SIGNATURE <i>Edmond I. Moushabek</i>		DATE SIGNED <i>Glen Burnie, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>EDMOND I. MOUSHABEK</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Md.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>	
22d. DATE THEREOF <i>6-28-60</i>		22e. RECORD BY REGISTRAR DATE JUN 30 '60	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Singleton Funeral Home - Robert P. Ware</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06511

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY <i>A.A. Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>MD.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis - MD</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A.-Anne Arundel General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Stewart</i>	Middle <i>Pediefield</i>	Last <i>Parker</i>
4. DATE OF DEATH Month <i>6</i>	Day <i>10</i>	Year <i>1960</i>	
S. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/7/14</i>
			9. AGE (In years last birthday) <i>45 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrical Apparatus</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Acceptal</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Slowacki R. Parker</i>		14. MOTHER'S MAIDEN NAME <i>Emily Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>089-12-5883</i>	
		17. INFORMANT <i>Mr. Maurice Parker</i> Address <i>Oxford Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>424.4</i> DUE TO <i>Cancer disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Fallen</i>	
Conditions, if any, which gave rise to immediate cause (b) <i></i>			
(c) stating the underlying cause lost. <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Easton</i> (County) <i>Caroline</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>	DATE SIGNED <i>6-10-60</i>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/12/60</i>	22b. DATE THEREOF <i>6/12/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>King Hasan Meeting House</i>	22d. LOCATION (City, town, or county) <i>Easton</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Linhardt</i>		ADDRESS <i>Easton Md</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 14 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06512

6520

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 hr 8 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Annapolis, Md.		d. STREET ADDRESS U.S. Naval Hospital, Annapolis, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Phillip Edgar PETERSON		First	Middle	Lost	4. DATE OF DEATH June 30th 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-30-60	9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR 0 months	IF UNDER 24 HRS. 0 days	Hours 4	Min. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Richard Dale PETERSON		14. MOTHER'S MAIDEN NAME Alyce Jean SMITH						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Father - 28 Badger Road, Annapolis, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pre-maturity * ATELECTASIS 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 hr - 8 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) Maryland (State)
21. I certify that I attended the deceased from 12:47PM 6/30 1960 , to 4:55PM 6/30 1960 , that I last saw the deceased alive on 30 June 1960 , and that death occurred at 4:55P M , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED 1 July 60								
ACTUAL SIGNATURE I. C. Mazzarella		M.D.						
PHYSICIAN'S NAME (Type) I. C. Mazzarella, LT MC USN		U. S. Naval Hospital, Annapolis, Maryland						
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial July 5 1960		22b. DATE THEREOF July 5 1960		22c. NAME OF CEMETERY OR CREMATORIAL Naval Academy Cemetery		22d. LOCATION (City, town, or county) Annapolis		(State) Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons Annapolis Md		ADDRESS John M. Taylor & Sons Annapolis Md		24a. REC'D BY REGISTRAR DATE JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

66513

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Sherwood Forest				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		1325 Clapston Hill				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male		White		14-3-1905	53	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Salesmanager		Retail Sales		Lilting Pa.		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
John W. Pfautz Sr.		Harriett Reed Howell								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
(If yes, give war or dates of service)		160-01-9431		Margaret H. Pfautz		(2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Asphyxiation								
18-3-X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Cancer, Lung, Metastatic				22 Mos.				
DUE TO (b)		Cancer, Lung								
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Tranition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19										
21. I certify that I attended the deceased from 25 May, 1960, to 3 June, 1960, that I last saw the deceased alive on 25 June, 1960, and that death occurred at 4:30 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE		M.D.				38 Cornhill Annapolis, Md.				DATE SIGNED
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)		
Burial		6-29-1960		St. Anne's Cent		Annapolis		Md		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
John M. Taylor Sons		Annapolis, Md.		JUN 30 1960		Arthur J. Muller				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-20190-00023-S - STATEMENT OF EXPENSES FOR JUDGE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5521

CERTIFICATE OF DEATH

Reg. Dist. No. 06514

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>11 hrs</i>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>Anne Arundel Gen. Hosp.</i>		e. STREET ADDRESS <i>911 Central St.</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Leander</i>	Middle <i>Phelps</i>	Last 4. DATE OF DEATH <i>6 11 1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 17-93</i>
9. AGE (In years last birthday) yrs. <i>66</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>11</i>	12. Year <i>1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bldg. Attendant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
10c. BIRTHPLACE (State or foreign country) <i>Annapolis-Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Phelps</i>		14. MOTHER'S MAIDEN NAME <i>Anna Booze</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>W.W.I 819-16-0660A</i>	
17. INFORMANT <i>Maude-Phelps-911 Central St.</i>		Address <i>Annapolis-Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 hrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Vascular Disease</i>		5 yrs.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/25/1955</i> to <i>6/11/1960</i> , that I last saw the deceased alive on <i>6/11/1960</i> , and that death occurred at <i>8:25 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Therodore H. Johnson Jr. Hospital Street 6/3/60</i>	
ACTUAL SIGNATURE <i>Theodore H. Johnson Jr.</i>		DATE SIGNED <i>6/11/60</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Theodore H. Johnson, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-17-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>U.S. National</i>		22d. LOCATION (City, town, or county) <i>ANNAPOLIS - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Hicks III</i>		ADDRESS <i>Annapolis - Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 21 '60</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Hicks</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6522

CERTIFICATE OF DEATH

06515

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Severna Park				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General		d. STREET ADDRESS 10600 Cypress Creek Rd., Box 257-Cypress Creek Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Paul A. Pohlner		First	Middle	Last	4. DATE OF DEATH June 12	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1901 - Oct. 4th	9. AGE (In years lost birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY Md. Shipbuilding		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Louis R. Pohlner		14. MOTHER'S MAIDEN NAME Anne Hoyer		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-1590		17. INFORMANT Mrs. A. Paul Pohlner		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Rheumatic heart disease DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH 1 hour		
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b.						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb. 10, 1958 , to June 10, 1960 , that I last saw the deceased alive on June 7, 1960 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Severna Park, Md. DATE SIGNED 6-13-60								
ACTUAL SIGNATURE <i>Raymond Smith M.D.</i>		M.D.						
PHYSICIAN'S NAME (Type) Dr. Robert Hahn								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15 June		22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE R. Washington		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Turner		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06516

5562

CERTIFICATE OF DEATH

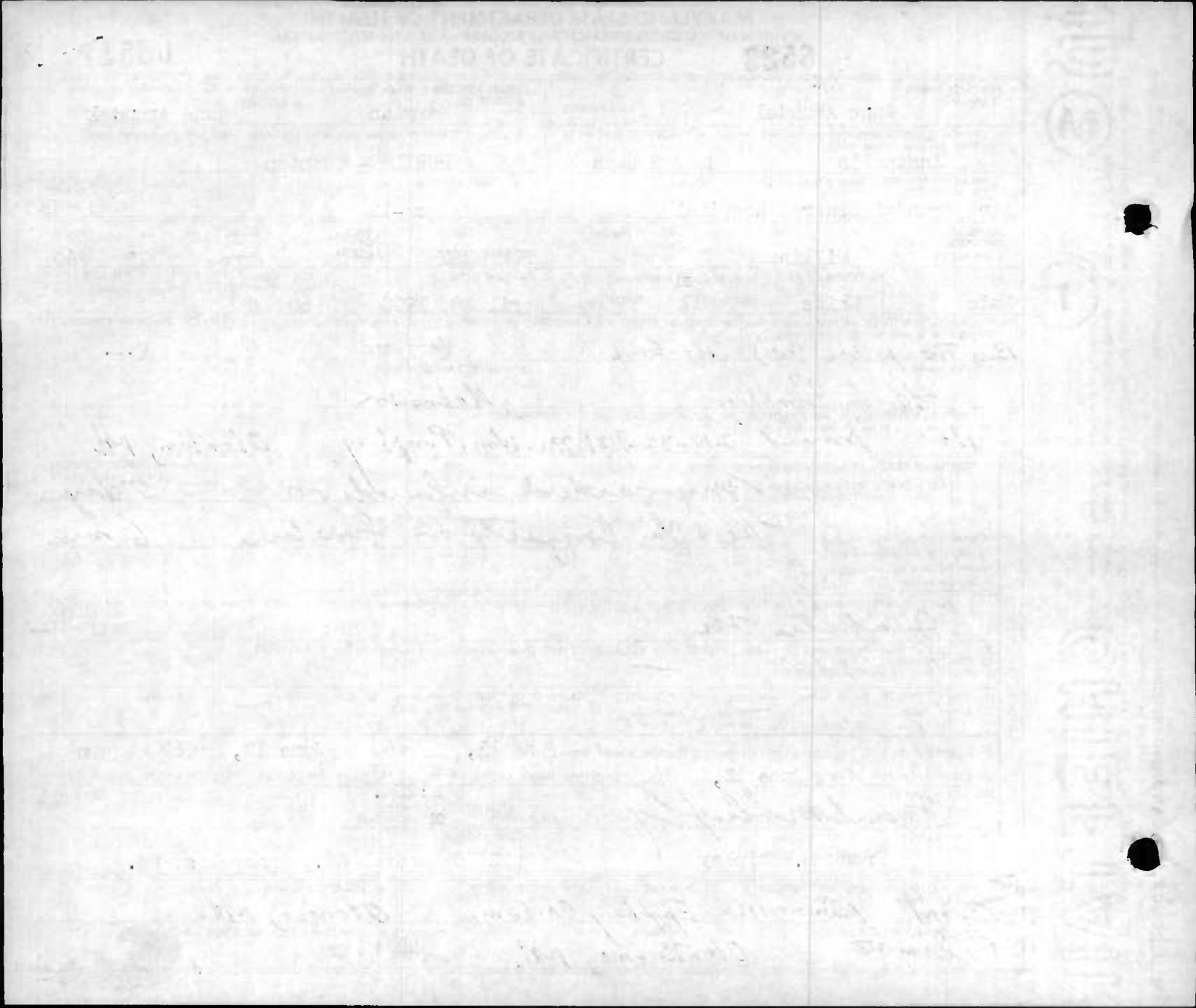
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 600 Balto.-Annap.Road,Ferndale		d. STREET ADDRESS 600 Balto.-Annap. Road,Ferndale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Alice		First	Middle Lehr	Last Pumphrey	4. DATE OF DEATH Month June	Day 4th	Year 19 60			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16th Dec. 1868	9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto. County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Abraham Rider		14. MOTHER'S MAIDEN NAME Margaret Merritt		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Cora E. Kelly, Same as #No. 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO		Hospicatory Failure		INTERVAL BETWEEN ONSET AND DEATH 2 m. n						
(b) DUE TO		Pulmonary Edema		10 days						
(c) DUE TO		Congestive Heart Failure		8 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sensitivity								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —								
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE R.W. Prichard PHYSICIAN'S NAME (Type) R.W. Prichard		ADDRESS (Street, city or town, state) 715 Cotter Rd Glen Glen Burnie, Md						DATE SIGNED 6/8/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7 June 1960		22c. NAME OF CEMETERY OR CREMATORIUM Friendship Cemetery		22d. LOCATION (City, town, or county) Anne Arundel, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Sington		ADDRESS Glen Burnie, Md		No. REC'D BY REGISTRAR JUN 8 '60		DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												06517	
6523 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland						b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Odenton			d. STREET ADDRESS Box-12			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital													
3. NAME OF DECEASED (Type or print)		First William		Middle		Last PUMPHREY		4. DATE OF DEATH June 13 1960		Month		Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 28, 1900		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Transportation (ret.)			10b. KIND OF BUSINESS OR INDUSTRY Self-Emp.			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Addison Pumphrey						14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-9181		17. INFORMANT Mr. Wm. Pumphrey		Address Odenton, Md.		INTERVAL BETWEEN ONSET AND DEATH 5 days.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to (c) Ac & Ch. Congestion Failure													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes m.													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from June 11, 1960 , to June 12, 1960 , that (I) (X) last saw the deceased alive on June 12, 1960 , and that death occurred at M , from the causes and on the date stated above.													
22a. SIGNATURE Frank M. Shipley						M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4:20A.	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley						22d. ADDRESS 121 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16 June 1960		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Epiphany Ch. Cem.		23d. LOCATION (City, town, or county) Odenton, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE R. W. Huntington						25a. REC'D BY REGISTRAR DATE JUN 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Moore					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G26 6-20-60 et

06518

CERTIFICATE OF DEATH

Reg. Dist. No.

6563

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				a. STATE	Md.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Stack Gry		50 days		H.H.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
707 Church St.		707 Church St.			
3. NAME OF DECEASED (Type or print)		First Middle (Quasny)		4. DATE OF DEATH Month Day Year	
WERNER A. QUASNY				6 - 9 1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
M		W		B. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 82 yrs.	
Painter		Paint		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Clarknowas		Clarknowas		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Address	
No				Frank J. Sauer	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
420. coronary occlusion					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.					
DUE TO (b) hypertension cardio resp. disease DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 10y					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				Jan 19 50, to June 10, 1960 4pm, from the causes and on the date stated above.	
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE					
PHILIP W. KEISTER					
PHYSICIAN'S NAME (Type)					
PHILIP KEISTER					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Cremation		6-13-60		Holy Cross	
22d. LOCATION (City, town, or county)				(State)	
Baltimore				Md.	
23. FUNERAL DIRECTOR'S SIGNATURE					
ADDRESS					
ARTHUR S. THAYER					
24a. REC'D BY REGISTRAR DATE JUN 14 '60					
24b. REGISTRAR'S SIGNATURE					
Arthur S. Thayer					

(Version)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6524

CERTIFICATE OF DEATH

06519

1. PLACE OF DEATH

a. COUNTY

Anne Arundel MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

8 Finkley St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY A.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

10 Annapolis

d. STREET ADDRESS

18 Finkley St.

e. IS RESIDENCE

ON A FARM?

YES NO

3. NAME OF

(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

S. SEX

Female

6. COLOR OR RACE

Col.

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10-8-1876

9. AGE (In years
last birthday)

83 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Address

13. FATHER'S NAME

Joseph Parker

14. MOTHER'S MAIDEN NAME

Amanda Pope

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

—

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Allen Queen - Annapolis, Md.

INTERVAL BETWEEN
ONSET AND DEATH

420.1

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause last.

{ (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING

CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a. m.

p. m.

20d. INJURY OCCURRED

While at work

Not while at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

6-4-59

19

, to

6-22-60

19

, that death occurred at

M

, from the causes and on the date stated above.

22a. SIGNATURE

G. T. Allen

M.D.

ATTENDING

PHYS.

MED.

DIRECTOR

STAFF

PHYS.

22b. DATE

SIGNED

6-24-60

1960

22c. PHYSICIAN'S

NAME (Type)

A. T. Allen

22d. ADDRESS

62 Rockwell St

Annapolis, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

6-24-60

Brewer & Still

Annapolis, Md.

23b. DATE THEREOF

ADDRESS

William Pease, Jr. Living: Md.

23c. NAME OF CEMETERY OR CREMATORI

Cemetery

Annapolis, Md.

23d. LOCATION (City, town, or county)

(State)

Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

William Pease, Jr. Living: Md.

ADDRESS

William Pease, Jr. Living: Md.

25a. REC'D BY REGISTRAR

DATE JUN 24 60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

1955-10-13 314

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 113520

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a separate sheet of paper, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. LENGTH OF STAY IN lb 13 years						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4935 Brookwood Road.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Paul Leroy Redden		First Paul	Middle Leroy					
4. DATE OF DEATH June 19th, 1960		Last Redden	Month June					
5. SEX M		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH 6/3/02		9. AGE (In years from birthday) 58 yrs.						
		IF UNDER 1 YEAR Months 5						
		IF UNDER 24 HRS. Days 8						
		Hours 0						
		Min. 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man at Hoschild Kohn		10b. KIND OF BUSINESS OR INDUSTRY Norfolk, Va.						
11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Herman Redden		14. MOTHER'S MAIDEN NAME Bessie Moore						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) National Guard 21 Years		16. SOCIAL SECURITY NO. 217-07-9532						
17. INFORMANT Mrs. Edith Mae Redden (wife)		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion								
450.1 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Brooklyn	(County) Md.	(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/19/60		
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/60	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.		22d. LOCATION (City, town, or county) Brooklyn, Md.		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes 130 E. Fort Ave.</i>		ADDRESS <i>Salisbury</i>		24a. REC'D BY REGISTRAR DATE JUN 22 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6565

CERTIFICATE OF DEATH

06521

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6 yrs. 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Abdul	Middle 	Last Rezar
4. DATE OF DEATH	Month June	Day 23	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894?
9. AGE (In years last birthday) 66?	10. IF UNDER 1 YEAR Months 66	11. IF UNDER 24 HRS. Days 7 yrs.	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Unknown	12. CITIZEN OF WHAT COUNTRY? Unknown
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO. -----	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			
420-1 DUE TO Conditions, (if any, which gave rise to immediate cause (a), stating the underlying cause lost.) (b) Hypertensive Cardiovascular Disease			
DUE TO (c) Schizophrenic Reaction, Paranoid Type			
INTERVAL BETWEEN ONSET AND DEATH -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, Paranoid Type			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. ----- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from April 23 1954 to June 23 1960 , that (I) (we) last saw the deceased alive on June 23 1960 , and that death occurred at at home , from the causes and on the date stated above.			
22a. SIGNATURE Hildegard H. Reissmann	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Hildegard H. Reissmann	22d. ADDRESS Crownsville State Hospital, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-28-1960	23c. NAME OF CEMETERY OR CREMATORIAL HOME St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Hildegard H. Reissmann	ADDRESS 1631 Grand Hill Ave.	25a. REC'D BY REGISTRAR JUN 29 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Khan

monday

Wednesday

Thursday

Wednesday 20th January 1942

and I am not otherwise

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06522

Reg. Dist. No.

6565

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE						
Anne Arundel		MARYLAND Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
P.O. Annapolis		15 minutes X P.O. Annapolis						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS						
Mill Creek, 10 feet of the shore.		Brownwood Ed. Route 4						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Warren Paul Ridge					June 1st.	19	60	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/23/57	3 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
None				Glen Burnie, Md.		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
William Ridge		Mary Mae Pumphrey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		None		William Ridge (father)				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drawing INTERVAL BETWEEN ONSET AND DEATH 850X DUE TO Sudden</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____</p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off a row boat into 4 feet of water.</p>								
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
4:50 P.M. 6/1/60 19				Mill Creek		P.O. Annapolis, A.A. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE		DATE SIGNED						
Gustave H. Faubert, M.D.		6/1/60						
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
Gustave H. Faubert, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)		
Burial		4-June 60		Glen Haven Cemetery		Glen Burnie, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Robert P. Ware - Glen Burnie		Singleton Funeral Home		DATE JUN 8 '60		Arthur S. Kline		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

SE ZBUDOWAŁA W 1920 ROKU W WIELKIEJ BIAŁORUŚCIE, A W 1939 ROKU BYŁA WŁASNOŚCIĄ ZSRR.

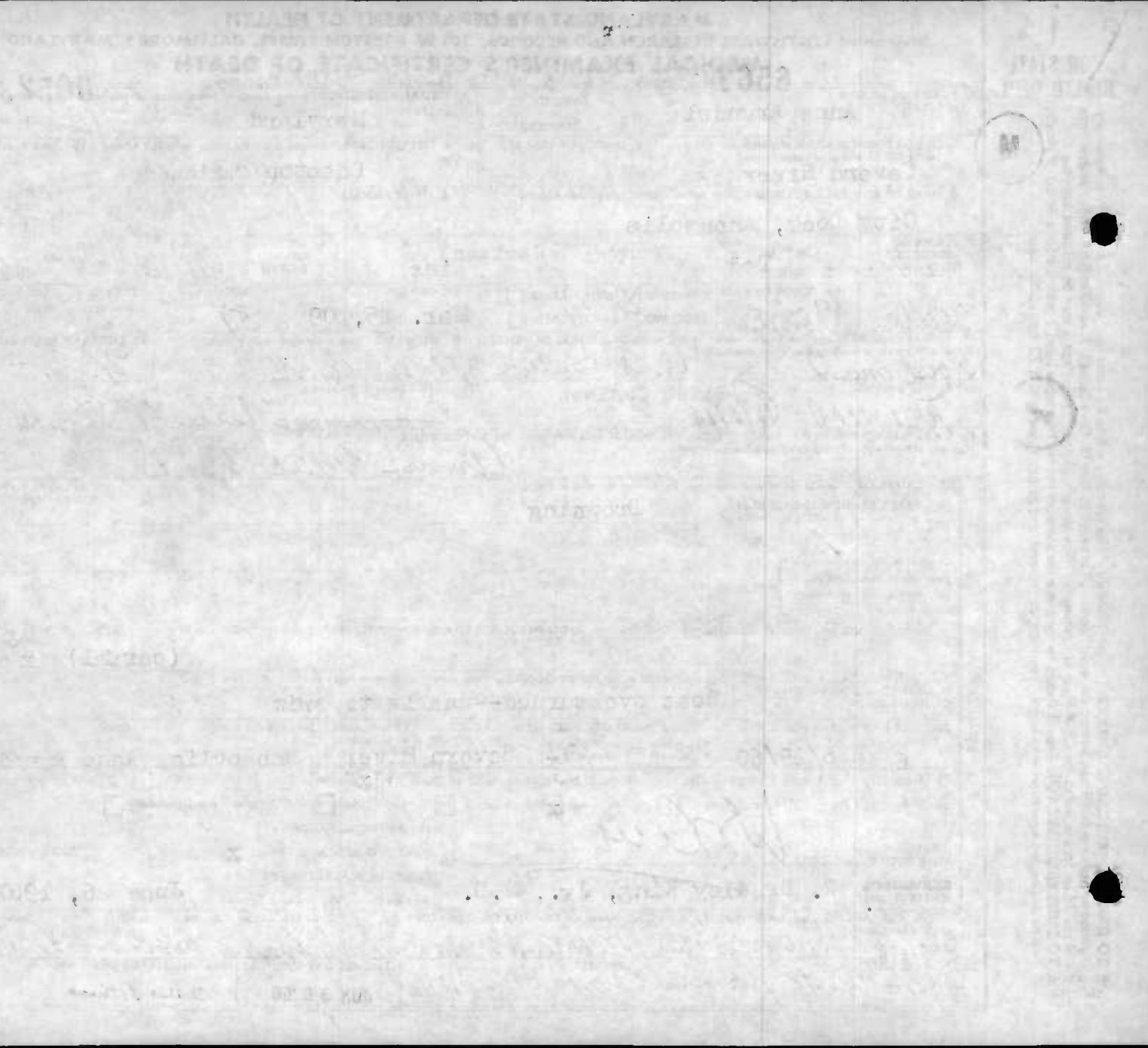
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18. Give Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel	656? Items 3 & 13, Film G-267 7/18/60 case. & 2c	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	06523 b. COUNTY Oakland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn River	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton Oakland	d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) City Dock, Annapolis	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Also known as) Carl Perry Jamison Rine	First Ted	Middle Perry	Last Jamison	4. DATE OF DEATH June 24th 1960	Month June	Day 24	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 09	9. AGE (In years last birthday) 51 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road man	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Rine	14. MOTHER'S MAIDEN NAME Bliss Jamison	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or details of service)	16. SOCIAL SECURITY NO. 17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? (partial) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat overturned--unable to swim	20c. TIME OF INJURY Hour a.m. 6 p.m. Month, Day, Year 6/25/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Severn River	20f. (City or town) Annapolis	(County) Anne Arundel	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	ACTUAL SIGNATURE W. Bradley King, Jr., M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED June 26, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 25th 1960	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial	22d. LOCATION (City, town, or county) Annapolis Md	(State)			
23. FUNERAL DIRECTOR John W. Taylor Sons Annapolis Md	ADDRESS 101 W. Taylor St. Annapolis Md	24a. REC'D BY REGISTRAR JUN 30 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause				



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial; cremation, or removal, and in any event within 72 hours after death.

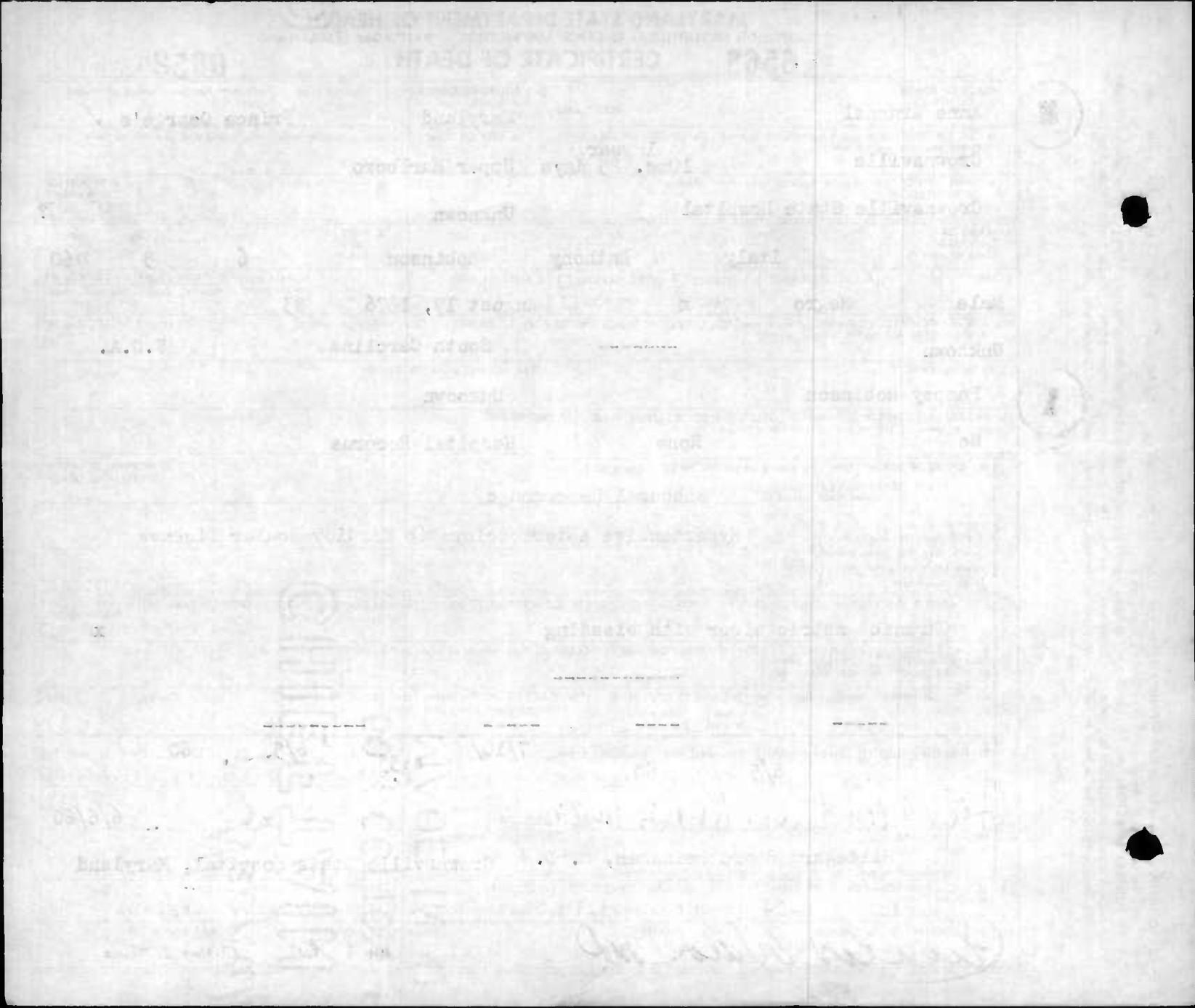
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6568

CERTIFICATE OF DEATH

06525

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 10mo. 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital							
3. NAME OF DECEASED (Type or print) Italy		First Anthony	Middle 	Last Robinson	4. DATE OF DEATH 6	Month 5	Day 1960
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 19, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 83	IF UNDER 24 HRS. Days 0	Year 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pampey Robinson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 44-2X PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic gastric ulcer with bleeding							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. ----- p. m. ----- 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 7/10/1958 to 6/5/1960 , that (I) (we) last saw the deceased alive on 6/5/1960 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				22b. DATE SIGNED 6/6/60			
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6-8-60		23c. NAME OF CEMETERY OR CREMATORIAL Crownsville State Hosp.		23d. LOCATION (City, town, or county) (State) Crownsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles Ward MD				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 1 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06526

Reg. Dist. No. 1

PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>					
<u>Old Annapolis Road</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>102 37th Kendree Ave</u>					
3. NAME OF DECEASED (Type or print)		First <u>Hanford</u>	Middle <u>L.</u>	Last <u>Sarles</u>	4. DATE OF DEATH	Month <u>6</u>	Day <u>6</u>	Year <u>1960</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-1899</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr. Merchant's Store U.S. Naval Academy</u>		11. BIRTHPLACE (State or foreign country) <u>Oxford Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>N. S. A.</u>			
13. FATHER'S NAME <u>Benjamin E. Sarles</u>		14. MOTHER'S MADDEN NAME <u>Grace M. Redden</u>		Address <u>Florence L. Sarles</u> (2)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Benjamin E. Sarles</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last		(b)		(c)		<u>Indoor Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Annapolis</u>	(County) <u>Md.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. L. Shaskoff</u>		EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>6-6-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-1960</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Cedar Bayou Cemt</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons Annapolis Md</u>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>			
DATE JUN 10 '60									

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

VS. A15ME(5)
5M 9/55

...THE STATE OF DEATH IS AN IMAGE OF ETERNAL LIFE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G265 6-17-60 et

CERTIFICATE OF DEATH

06527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Linthicum</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>320 Church Circle</i>		d. STREET ADDRESS <i>320 Church Circle</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Katie</i>	Middle <i>Schillingberg</i>	Last <i>June 10 1960</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>10</i>	Year <i>1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1874</i> March 8, 1874 9. AGE (In years (last birthday) <i>86 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>? Doerr</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Schmidt</i>	Address <i>Linthicum Hgts. Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mildred C. Smith 320 Church Circle</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422</i> DUE TO <i>Cardio-Vascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ DUE TO _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>June 10, 1959</i> , to <i>June 10, 1960</i> , that I last saw the deceased alive on <i>June 10, 1960</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>108 Carter Dr Glen Burn</i> DATE SIGNED <i>June 11, 1960</i>			
ACTUAL SIGNATURE <i>James S. Bullock</i>	M.D. <i>108 Carter Dr Glen Burn</i>		
PHYSICIAN'S NAME (Type) <i>James S. Bullock</i>	, 08 Carter Dr Glen Burn 4		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/14/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i>	ADDRESS <i>4107 Wilkens Avenue</i>	24a. REC'D. BY REGISTRAR DATE <i>JUN 14 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 350M1100-111230 90 111310 1112 1112 1112 1112 1112 1112 1112

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06528

6528

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Md.		b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Arnold		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Arnold	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Own Home		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Fitzhue (Fritz)	Middle Lee	Last Sears	4. DATE OF DEATH	Month June	Day 28	Year 1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 75 yrs.	IF UNDER 24 HRS. Hours Days		
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 6, 1885	75 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Painter			Retired		Anne Arundel Co,		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
Unknown John Wesley Sears			Unknown Mary Elizabeth Phipps						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		213-18-6467		Raymond B. Sears, same as 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Personary Occlusion</i> Interval between onset and death sudden									
420.		DUE TO							
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>G. H. Faubert, M.D.</i>		DATE SIGNED <i>6/29/40</i>							
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Bluff		22d. LOCATION (City, town, or county) Annapolis, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home, Annapolis, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR JUL 1 '60		24b. REGISTRAR'S SIGNATURE <i>Claima & Thomas</i>			

81. **BRONFENBRENNER** (1979) SUGGESTS THAT THE PARENTING STYLES OF PARENTS ARE RELATED TO THE PARENTS' OWN PARENTING STYLES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6572

CERTIFICATE OF DEATH

06529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>9 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>614 Balto-Annap-Bldg N.E.</i>		d. STREET ADDRESS <i>1614 Balto-Annap.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>First: Neula Middle: Q. Last: Shea</i>		4. DATE OF DEATH Month Day Year <i>June 16, 1960</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>22 March 1895</i>		9. AGE (In years last birthday) yrs. <i>65</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Our Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pascoag, Rhode Island</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>James Stuart</i>		14. MOTHER'S MAIDEN NAME <i>Octavia Burton</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Geraldine Kearns</i>		Address <i>Same As #2</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Hypertensive Cardio-Vascular</i>		Cerebral Hemorrhage		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>12/15/60</i> , 19 <i>60</i> , to <i>12/16/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>6-15-60</i> , 19 <i>60</i> , and that death occurred at <i>443x</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles R. McDonald</i>		ADDRESS (Street, city or town, state) <i>2844 Green Hwy.</i>		DATE SIGNED <i>6-17-60</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 21st June 1960</i>		22b. DATE THEREOF <i>21st June 1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>All Hallows Ch. Cem.</i>		22d. LOCATION (City, town, or county) <i>Mosby, Conn.</i>		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. T. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REG'D. BY REGISTRAR <i>JUN 20 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>									

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF DEATH

DEATH CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525 CERTIFICATE OF DEATH

06531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>a.a.</i>		MARYLAND <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Edgewater</i>	
d. STREET ADDRESS <i>Pt 2 - Box 213 Edgewater Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alma</i>		First <i>Alma</i>	Middle <i>Gloria</i>
		Last <i>Simon</i>	4. DATE OF DEATH Month <i>6</i> Day <i>26</i> Year <i>1960</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct 8-1876</i>
8. AGE (In years last birthday) <i>83 yrs.</i>		9. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Franz Groll</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>Mrs Leonard E. Weaver</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pneumonitis</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Inter-trochanteric fracture of left femur and proximal fracture of left humerus.</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Edgewater</i> (County) <i>Maryland</i> (State) <i>MD</i>	
21. I certify that I attended the deceased from <i>Oct. 10, 1958</i> , to <i>June 25, 1960</i> , that I last saw the deceased alive on <i>June 26, 1960</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>Mayo Road</i> DATE SIGNED <i>June 26, 1960</i>			
ACTUAL SIGNATURE <i>Sylvia M. Lim</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim</i> , <i>Edgewater, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-28-1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	
24a. REC'D BY REGISTRAR <i>JUN 29 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Orlina S. Evans</i>	
DATE			

PIANO RO STADIKO

1870

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06532

6574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Edna	Last Smith
4. DATE OF DEATH	Month 6	Day 14	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alexander Williams	14. MOTHER'S MAIDEN NAME Elizabeth Quickly		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Hypostatic 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Hypertension Cardiovascular Disease (c) Since Admission			
INTERVAL BETWEEN ONSET AND DEATH 48 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/25 1960 , to 6/14 , 1960 , that (I) (we) last saw the deceased alive on 6/14 , 1960 , and that death occurred at 7:00 A.M., from the causes and on the date stated above.			
22a. SIGNATURE H. Benedict, M.D.		22b. DATE SIGNED 6/14/60	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/60	
23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Rest		23d. LOCATION (City, town, or county) Towson, Baltimore Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William L. Phatman		ADDRESS 1701 McEnery St.	
		25a. REC'D BY REGISTRAR DATE JUN 17 '60	
		25b. REGISTRAR'S SIGNATURE Shirley E. Turner	

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6526

CERTIFICATE OF DEATH

06533

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 5 Days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Wilson	Middle 	Last SMOTHERS, Sr.			
4. DATE OF DEATH June	Month 	Day 6	Year 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31-1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL UTILITIES		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Wesley Smothers		14. MOTHER'S MAIDEN NAME Lucy Harris		Address: Best Gate - Rd Marguerite Smothers-Annapolis-Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. W.W.I 32-10-2815		17. INFORMANT Acute Lymphemia		INTERVAL BETWEEN ONSET AND DEATH 1st.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) June 6, 1960	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to June 6, 19 60, that (I) (he) last saw the deceased alive on June 6, 1960, and that death occurred at _____ M, from the causes and on the date stated above.		22a. SIGNATURE Shuler H. Johnson M.D.				
22c. PHYSICIAN'S NAME (Type) T. H. Johnson		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/1/60
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-9-60	23c. NAME OF CEMETERY OR CREMATORIAL Carter Mem. Park	23d. LOCATION (City, town, or county) Laurel	(State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks II		ADDRESS Annapolis-Md.	25a. REC'D BY REGISTRAR DATE JUN 9 '60	25b. REGISTRAR'S SIGNATURE Cirrus S. Kraus		

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

ST. LOUIS FIELD OFFICE

2567

2442

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
ST. LOUIS FIELD OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6575

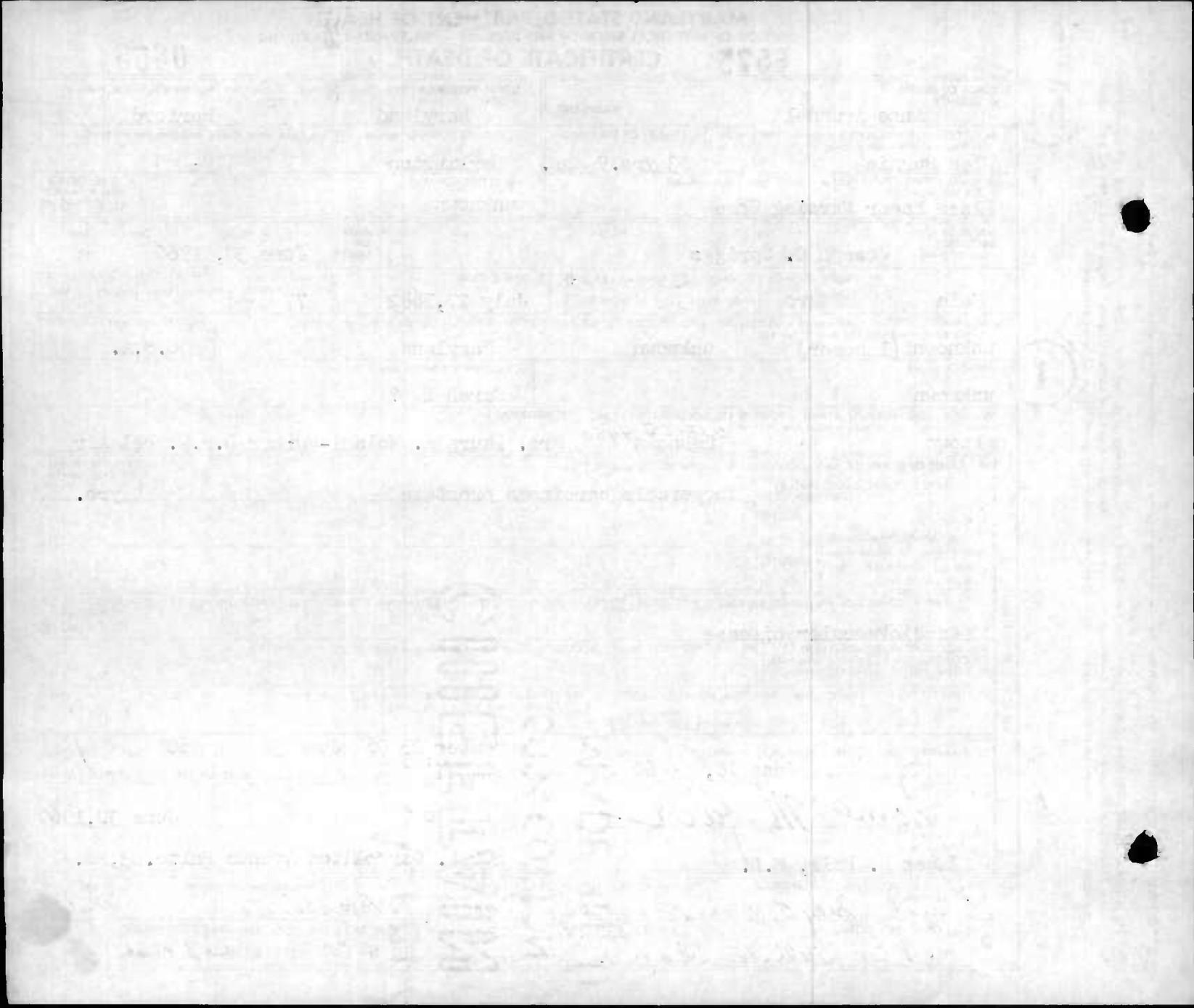
CERTIFICATE OF DEATH

06534

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 3 yrs. 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph C. Spriggs		First	Middle
		Last	4. DATE OF DEATH June 30, 1960
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown (laborer)		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Sarah E. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 218-05-4480	17. INFORMANT Mrs. Laura R. Moladi-Worker D.P.W. Bel Air
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inoperable carcinoma prostate		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 27, 1956 to June 30, 1960 , that (I) (we) last saw the deceased alive on June 18, 1960 , and that death occurred at 12:15 A.M. M. from the causes and on the date stated above.		22b. DATE SIGNED June 30, 1960	
22a. SIGNATURE James M. Pair		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 5, 1960	
		23b. DATE THEREOF July 5, 1960	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Berkley Cemetery 556 Lapis Street
24. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock - Hause de Gruy, Inc.		23d. LOCATION (City, town, or county) Darlington, Md.	25d. REC'D BY REGISTRAR DATE JUL 6 '60
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6536
Reg. Dist No. 06535

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>1½ yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>27 Brookfield Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(MATTIE) Martha Philemina Stewart</u>		First <u>Martha</u>	Middle <u>Philemina</u>
4. DATE OF DEATH <u>6/13/60</u>		Last <u>S</u>	Month <u>6</u> Day <u>8</u> Year <u>1960</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alleghany Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James J. Rowan</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Arnold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT <u>Mrs. R. M. Marley (Granddaughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420-1</u>			
(b) <u>General Arterio-sclerosis</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>G. H. Faubert, M.D.</u>		DATE SIGNED <u>6/8/60</u>	
EXAMINER'S NAME (Type) <u>Dr. G. H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) <u>Woodlawn Cem.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCullough Funeral Home 130 E Fort Ave #30</u>		ADDRESS	24a. REC'D BY REGISTRAR <u>Arthur S. Hayes</u>
		DATE <u>JUN 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hayes</u>

TO HOSPITAL may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6527

CERTIFICATE OF DEATH

06536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 19 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Herbert	Middle SUNDERLAND	4. DATE OF DEATH Month June 7 Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25th 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary-Salesman	10b. KIND OF BUSINESS OR INDUSTRY Printing	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benj. C. Sunderland	14. MOTHER'S MAIDEN NAME Mary G. Isaac		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO. 213-18-7611a	INFORMANT Mrs Herbert Sunderland	Address Severna Park Maryland.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis, generalized (c) 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1955 , to June 1960 that I last saw the deceased alive on June 7, 1960 and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francis I. Codd</i>		ADDRESS (Street, city or town, state) Severna Park, Maryland DATE SIGNED	
PHYSICIAN'S NAME (Type) Francis I. Codd M.D.			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF June, 10th 1960	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edith L. Amoreau</i>	ADDRESS 1003 W. Baltimore St.	24a. REC'D BY REGISTRAR DATE JUN 9 '60	24b. REGISTRAR'S SIGNATURE <i>Edith L. Kraus</i>

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Table 2. Results

-273-
4

Digitized by srujanika@gmail.com

TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Filing 265 6-27-60 et

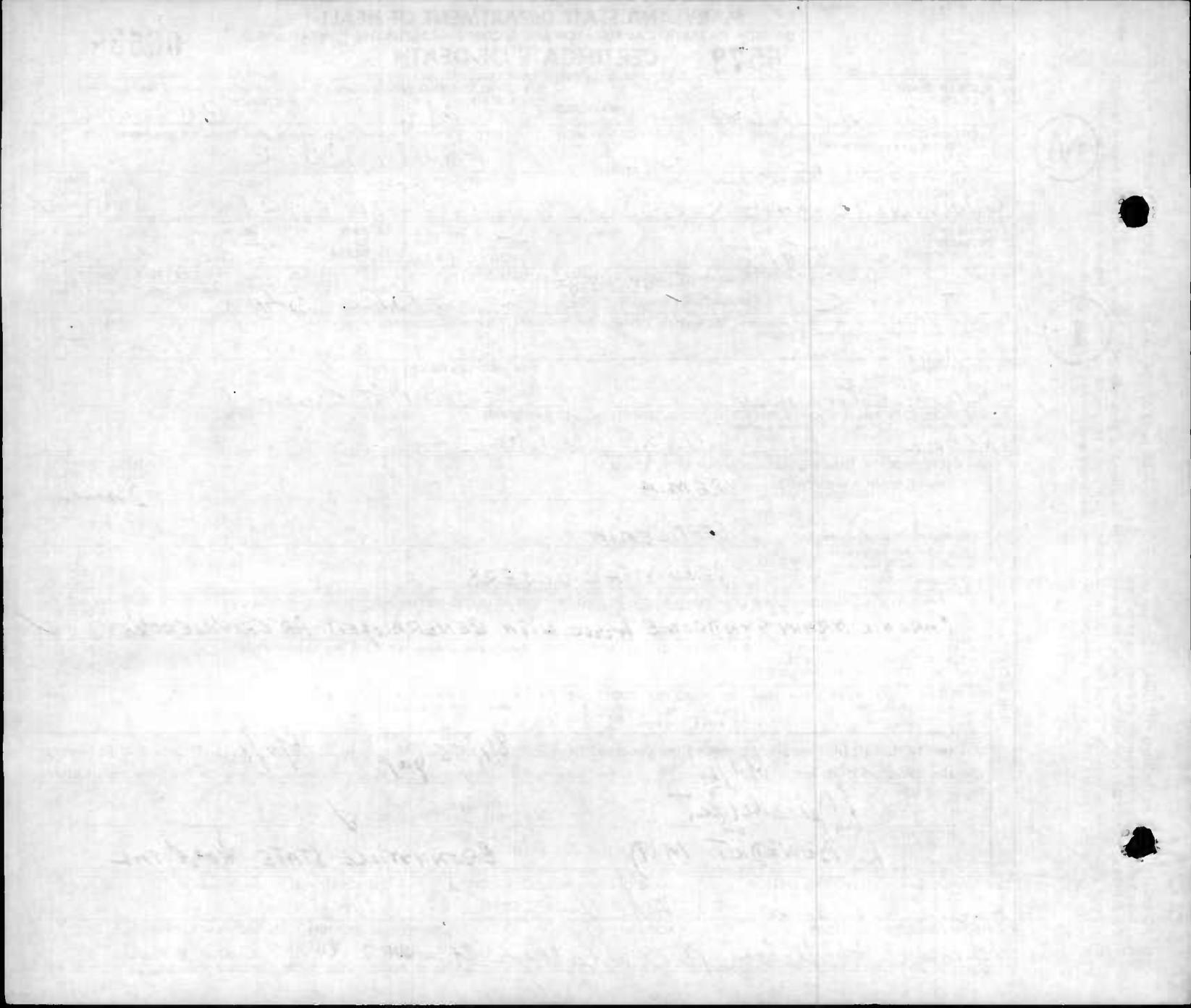
65537

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 3 mo. 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1923 Oak Hill Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Willie		First	Middle	Last	4. DATE OF DEATH Thomas	Month 6	Day 15	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----								
20c. TIME OF INJURY Month, Doy, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----		
21. I certify that (I) (this hospital) attended the deceased from 4/7 1924 to 6/15 1960, that (I) (we) last saw the deceased alive on 6/15 1960, and that death occurred at 8:59 P.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>L. Benedict, M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/16/60
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland						
23a. BURIAL CREMATION, REMOVAL (If none, skip) Burial		23b. DATE THEREOF 6/16/60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS My Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore		
24. FUNERAL DIRECTOR'S SIGNATURE Rayner Sender 217 E Preston St		ADDRESS		25d. REC'D BY REGISTRAR DATE JUN 21 '60		25e. REGISTRAR'S SIGNATURE Charles S. Thrush		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												06538					
6578 Item 7 Film 6264 6-14-60 66																	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)													
a. COUNTY <i>ANN ARUNDEL</i>				a. STATE <i>Md.</i>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CROWNVILLE.</i>				b. COUNTY <i>BALTIMORE</i>													
c. LENGTH OF STAY IN 1b <i>5 yrs</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownville State Hosp.</i>				d. STREET ADDRESS <i>1115 Striker St.</i>													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <i>Fannie</i>				First	Middle	Last	4. DATE OF DEATH <i>Tompkins</i>	Month <i>JUNE</i>	Day <i>4</i>	Year <i>1960</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-22-1906</i>		9. AGE (In years last birthday) <i>54 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charlie Ferguson</i>				14. MOTHER'S MAIDEN NAME <i>Amelia Alexander</i>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>UNK</i>				17. INFORMANT <i>CHART</i>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i>																	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>715X</i>																	
(b) <i>SEPTICEMIA</i>																	
DUE TO (c) <i>DECUBITUS ULCERS</i>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i> <input type="checkbox"/>					
<i>CHRONIC BRAIN SYNDROME Assoc. WITH GENERALIZED ARTERIOSCLEROSIS</i>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <i>Baltimore</i>		(County) <i>Md.</i>	(State) <i>Md.</i>		
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (II) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.																	
22a. SIGNATURE <i>L. Benedict M.D.</i>												22b. DATE SIGNED <i>6/4/60</i>					
22c. PHYSICIAN'S NAME (Type) <i>L. Benedict M.D.</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <i>Crownville State Hospital</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6/9/60</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Auburn</i>				23d. LOCATION (City, town, or county) <i>Md.</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Nelson</i>				ADDRESS <i>1348 W Calhoun St.</i>				25a. REC'D BY REGISTRAR <i>JUN 7 '60</i>				25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG265 6-17-60 et

06539

Reg. Dist. No.

6579

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i> Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jewell</i>	c. LENGTH OF STAY IN 1b <i>RURAL</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jewell Road</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i>Dunkirk Md.</i>					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First MAURICE	Middle E.	Last TURNER				
4. DATE OF DEATH	Month June	Day 8	Year 1960				
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 7, 1892				
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0	Days 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland				
13. FATHER'S NAME James Turner		12. CITIZEN OF WHAT COUNTRY? Maryland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-16-1046	17. INFORMANT Mrs. Florence Turner				
		Address Jewell Road Dunkirk, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Coronary occlusion.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Huntingtown		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-10 - 1959 to 5/1/60 , 1960, that I last saw the deceased alive on 5/1/60 , 1960, and that death occurred at 1:30 p.m. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Huntingtown, Md 5/9/60			
ACTUAL SIGNATURE <i>G. J. Weems</i>		M.D.		DATE SIGNED 5/9/60			
PHYSICIAN'S NAME (Type) Dr. George J. Weems		Huntingtown		Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1960		22c. NAME OF CEMETERY OR CREMATORIUM St. James Church Cemetery		22d. LOCATION (City, town, or county) (State) A. A. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gutchins Funeral Home Owings Md.</i>		ADDRESS <i>Owings Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE <i>Calvin S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEVELOPMENT DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6500 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>A. A. Co</i>		a. STATE <i>Md</i>	b. COUNTY <i>AA</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOA U.S. NAVAL HOSPT.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. STREET ADDRESS <i>204 S. Cherry Grove Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Otis</i>		First <i>Otis</i>	Middle <i>A</i>
Last <i>Van Denburgh</i>		4. DATE OF DEATH	Month <i>6</i> Day <i>7</i> Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <i>Sept 10-1892</i>	
9. AGE (In years for birth year) yrs. <i>67</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MECHANICAL Eng U.S.N.E.S.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>TROY N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>OTIS A. VAN DENBURGH</i>		14. MOTHER'S MAIDEN NAME <i>GERTRUDE DEFREEST</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>W. Wur I</i>	
17. INFORMANT <i>Elizabeth S. Van Denburgh</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Disease</i> DUE TO <i>434.4</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>E. Linhardt</i> 6-7-60	
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>6-9-1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Holloway Mem. Cemetery Annapolis Md.</i>	
22d. LOCATION (City, town, or county) <i>Annapolis Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>	
ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 10 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

WEDNESDAY, NOVEMBER 22, 1972
THE DAILY NEWS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6528

CERTIFICATE OF DEATH

Reg. Dist. No.

06541

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 8 days X RURAL - Riva	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS Glen Isle Estates	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Stanley	Middle Allen	Last WADDELL
4. DATE OF DEATH June	Month 15	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 7, 1960
			9. AGE (In years lost birthday) yrs. Months Days Hours Min. 8 4 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stanley Leroy WADDELL		14. MOTHER'S MAIDEN NAME Fannie Mae TOY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.1 DUE TO congenital malformation of heart and aorta			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Atresia of left ventricle (c) DUE TO Atresia primum of aorta			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 7, 1960, to June 15, 1960, that I last saw the deceased alive on June 15, 1960, and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edith Rodler	M.D.	ADDRESS (Street, city or town, state) 45 Franklin St., Annapolis, Md.	DATE SIGNED 6/16/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8 June 1960	22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven	22d. LOCATION (City, town, or county) Glen Burnie, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE R. J. Singletor	ADDRESS Glen Burnie, Md.	24a. REC'D BY REGISTRAR DATE JUN 20 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/38

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6581

CERTIFICATE OF DEATH

06542
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital, Ft Geo G. Meade, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Suzanna	Middle Marie	Last Ward
4. DATE OF DEATH	Month June	Day 12	Year 19 60
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> N/A	8. DATE OF BIRTH 5 June 60
9. AGE (In years lost birthday) yrs. 7	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.	13. FATHER'S NAME Frederick D. Ward		
14. MOTHER'S MAIDEN NAME Rosemarie Boller	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		
16. SOCIAL SECURITY NO. - - - - -	INFORMANT Father	Address 1216 Annapolis Road, Odenton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 June 1960 , to 12 June 1960 , that I last saw the deceased alive on 12 June 1960 , and that death occurred at 11:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>ROY M. Slezak</i>	ADDRESS (Street, city or town, state) USA Hospital Ft Geo G Meade, Md		DATE SIGNED 12 June 60
PHYSICIAN'S NAME (Type) ROY M. SLEZAK, CAPT., M.C.	U.S. Army Hospital, Ft Geo G. Meade, Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 14 June 1960	22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Cemetery	22d. LOCATION (City, town, or county) Glen Burnie (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Singleton-Funeral Home, Robert P. Ware	ADDRESS Glen Burnie, Maryland	24a. REC'D BY REGISTRAR JUN 15 1960	24b. REGISTRAR'S SIGNATURE Robert P. Ware

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06543

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fernside</i>	c. LENGTH OF STAY IN 1b <i>35 yr.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jarm</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Vista Acr - (South)</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>LeRoy</i>	First <i>Frederick</i>	Middle <i>Herman</i>	Last <i>Wasmus</i>
4. DATE OF DEATH <i>June 18 1960</i>	Month <i>June</i>	Day <i>18</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb-27-1911</i>
9. AGE (In years lost birthday) <i>49 yrs.</i>	10. IF UNDER 1 YEAR Months <i>49</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driller Shop yard</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Metastatic Ca - origin unknown</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Same</i>
13. FATHER'S NAME <i>Frederick H. Wasmus</i>	14. MOTHER'S MAIDEN NAME <i>Rebecca m. Wilder</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216-09-6777</i>	17. INFORMANT <i>LeRoy Wm. Wasmus - same</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) <i>In liver - Brain & glands</i> DUE TO (c) <i>Metastatic Ca - origin unknown</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>6-7mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had biopsy at University Hosp.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>From</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Brooklyn Md.</i>
20f. (City or town) <i>Brooklyn</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>May 1, 1960</i> , to <i>6/18, 1960</i> , that I last saw the deceased alive on <i>6/18, 1960</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i>			ADDRESS (Street, city or town, state) <i>Linthicum</i>
PHYSICIAN'S NAME (Type) <i>None</i>			DATE SIGNED <i>6/18/60</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-21-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cen</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCally Funeral Home 130E York Ave</i>		ADDRESS <i>130E York Ave</i>	24a. REC'D BY REGISTRAR DATE JUN 22 '60
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

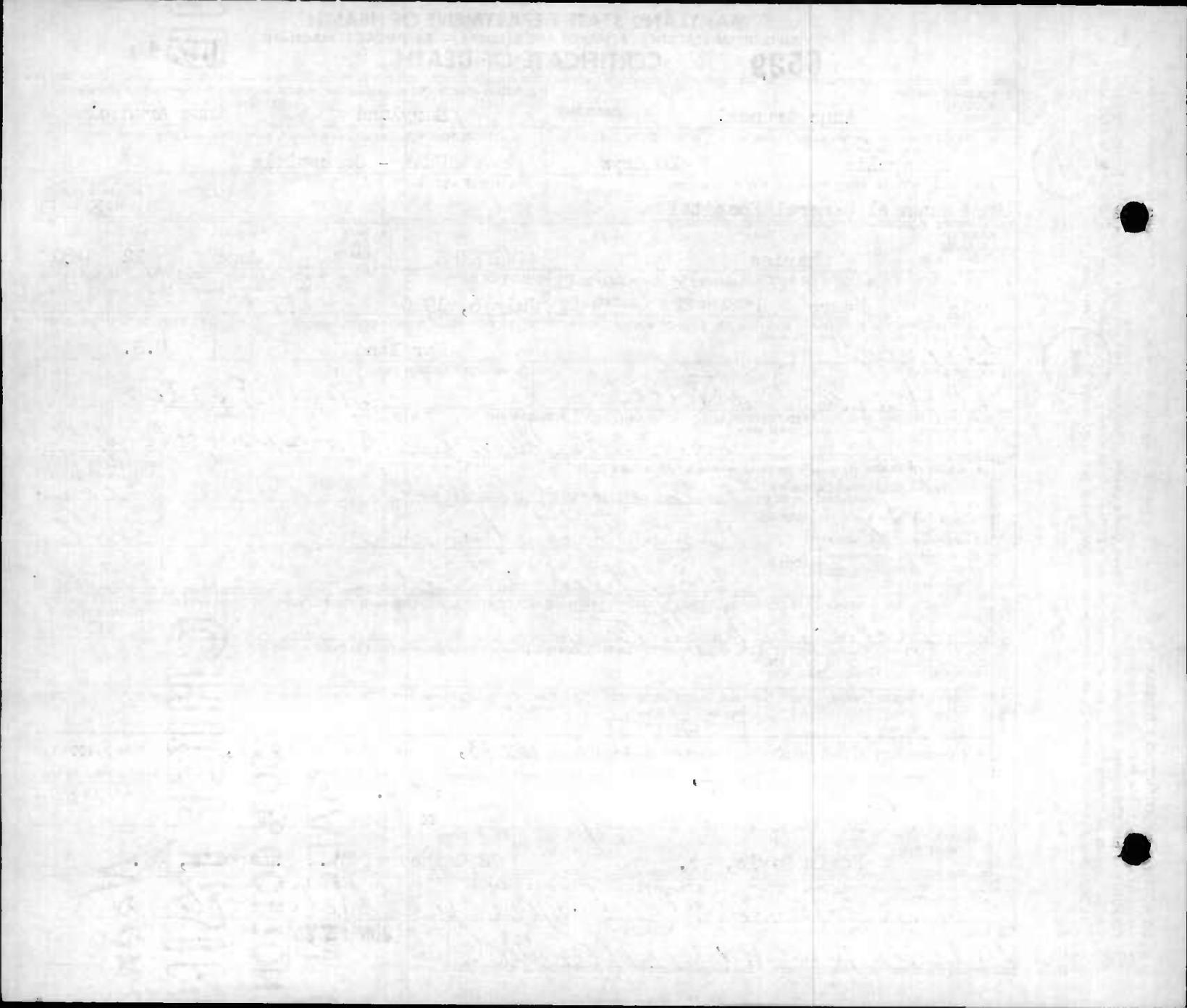
may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6529 06544

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b 20 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Galesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print)	First Charles	Middle WATKINS	Last June 12 1960
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joshua Watkins		14. MOTHER'S MAIDEN NAME Mary Foster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-5158 17. INFORMANT Mamie Watkins Galesville Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 108x DUE TO Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perinephritis abscess (c) Methanol stricture		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 weeks 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED While Not while p. m. 19 of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) June 11, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1960, to June 11, 1960, that (I) (we) lost saw the deceased alive on June 11, 1960, and that death occurred at M, from the causes and on the date stated above.		6:00 A.M.	
22a. SIGNATURE Edwin Davis, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.		22d. ADDRESS 98 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-15-1960	
23c. NAME OF CEMETERY OR CREMATORIAL Cheverus Memorial		23d. LOCATION (City, town, or county) Galesville Md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE William Keestell Anna Md		25a. REC'D. BY REGISTRAR JUN 19 1960	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Knoll	
DATE			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. LENGTH OF STAY IN lb 3 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 Doris Ave.			d. STREET ADDRESS 117 Doris Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Susan Elizabeth Weiss		First	Middle	Last	4. DATE OF DEATH Month September Day 28 Year 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1895	
9. AGE (In years lost birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Joseph Hogan			14. MOTHER'S MAIDEN NAME Bridget Ready		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frances R. Parsick 117 Doris Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H.D.			INTERVAL BETWEEN ONSET AND DEATH Cerebral vascular accident		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. H.A.D.		DUE TO (b)		ASC + HD.	
		DUE TO (c)		 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1960 to 28 days before , that (I) (we) last saw the deceased alive on 27 Sept 1960 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Andrew R. Sosnowski M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 29, 1960	
22c. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski		22d. ADDRESS 4016 Ritchie Hwy. Balto. 25, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 1, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Schuylkill Memorial Cem.	
23d. LOCATION (City, town, or county) (State) Schuylkill Haven, Pennsylvania					
24. FUNERAL DIRECTOR'S SIGNATURE George Gore		ADDRESS 4001 Ritchie Hwy. Balto. 25, Md.		25a. REC'D BY REGISTRAR OCT 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Trahan					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6583 CERTIFICATE OF DEATH

66545

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 16 yrs. 6 mo. 18 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 410 Ogston Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lloyd	Middle	Last White	4. DATE OF DEATH	Month June	Day 22	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907?		9. AGE (In years last birthday) 52? yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 勞工		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Calvert Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack White		14. MOTHER'S MAIDEN NAME Mary Smallwood					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { DUE TO Cachexia (b) DUE TO Generalized Metastases (c) DUE TO Carcinoma of stomach							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Chronic Brain Syndrome with Central Nervous System Syphilis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour a.m. - - - - 19 - - - - p.m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 4, 1943 , to June 22, 1960 , that I last saw the deceased alive on June 22, 1960 , and that death occurred at 1:50 a.m. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. Crownsville State Hospital, Md. June 22 60							
DATE SIGNED							
ACTUAL SIGNATURE John Benedict							
PHYSICIAN'S NAME (Type) L. Benedict, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 埋葬		22b. DATE THEREOF 6/27/60		22c. NAME OF CEMETERY OR CREMATORIUM Mt Auburn		22d. LOCATION (City, town, or county) Baltimore (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes		ADDRESS 638 n. Gilmon St		24a. REC'D BY REGISTRAR DATE JUN 24 '60		24b. REGISTRAR'S SIGNATURE James S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6584

CERTIFICATE OF DEATH

06546
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena R.F.D.</i>		c. LENGTH OF STAY IN 1b <i>22 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena R.F.D.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9th st. & Catherine st., Green Haven</i>				d. STREET ADDRESS <i>9th st. & Catherine st., Green Haven</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>ROBERT</i>		First <i>ROBERT</i>	Middle <i>S.</i>	Last <i>WHITTAKER</i>	4. DATE OF DEATH <i>JUNE 20 1960</i>	Month <i>JUNE</i>	Day <i>20</i>	Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13 March 1906</i>		9. AGE (In years last birthday) <i>57 yrs.</i> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>American Oil</i>		11. BIRTHPLACE (State or foreign country) <i>Silverspring, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Robert S. Whittaker, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Lula Cooley</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-18-9482</i>		17. INFORMANT <i>Mrs. Alice C. Jensen, Samo as the 2</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA STOMACIT</i>		DUE TO <i>151X</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 MONTHS</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>BACONCHIECTASIS</i>		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>BACONCHIECTASIS</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Glen Haven Cemetery</i>		20f. (City or town) (County) (State) <i>Glen Burnie, Anne Arundel, MD</i>		
21. I certify that I attended the deceased from <i>4/16/60</i> , to <i>4/20</i> , 1960, that I last saw the deceased alive on <i>4/20</i> , 1960, and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. Brady Smith</i>		M.D.		ADDRESS (Street, city or town, state) <i>8471 Ft. Smallwood Rd. 02160</i>		DATE SIGNED		
PHYSICIAN'S NAME (Type) <i>J. Brady Smith</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>23 June 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Sampson</i>		ADDRESS <i>Glen Burnie, MD.</i>		24a. REC'D BY REGISTRAR DATE JUN 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

ANNUAL REPORT OF THE DEPARTMENT OF STATE DRAFTED AND PREPARED BY THE SECRETARY'S STAFF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6585 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06547

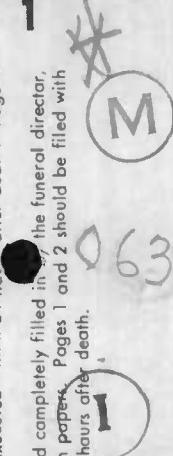
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	c. LENGTH OF STAY IN lb <i>5 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Routine - Bldg 183</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>George Samuel Williams</i>	First <i>G</i>	Middle <i>S</i>	Last <i>Williams</i>
4. DATE OF DEATH <i>June 6-</i>	Month <i>June</i>	Day <i>6</i>	Year <i>1960</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-4-1882</i>
9. AGE (in years) <i>78 yrs.</i>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.Q.</i>	
13. FATHER'S NAME <i>John Williams</i>		14. MOTHER'S MAIDEN NAME <i>Indra Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>Mrs. Edward Curzon Bugle</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>General Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Stable</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>General Arteriosclerosis</i> ?			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>6/6/60</i>	
ACTUAL SIGNATURE <i>Gustav H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>GUSTAV H. FAUBERT</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-11-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>MT. ZION CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>LAUREL, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles G. Cooper</i>		ADDRESS <i>CHARLES G. COOPER - 512 N. CARROLLTON AV.</i>	
24a. REC'D BY REGISTRAR <i>DANIEL 11 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Meach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6530

06548

CERTIFICATE OF DEATH

1. PLACE OF DEATH
o. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL and give nearest town
Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE

Maryland

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL
Annapolis

d. STREET ADDRESS

207 Severn Ave.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First Middle Last
Dorothea E WISEMAN

4. DATE
OF
DEATH

Month Day Year
June 2 1960

5. SEX

6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
Female White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 3, 1890 1887	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Ferdinand Freiderich

14. MOTHER'S MAIDEN NAME

Wilhmieni (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Fred A. Wiseman - Son - Severna Park, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last. (b)
 DUE TO
 (c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
of work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 2, 1960, to June 2, 1960, that (I) (we) last
saw the deceased alive on June 2, 1960, and that death occurred at M, from the causes and on the date stated above.

22o. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Richard N. Peeler

6/2 1960 7:05P.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

121 Cathedral St., Annapolis, Md.

22b. DATE
SIGNED
6/3/60

23a. BURIAL, CREMATION
1. REMOVAL (Specify)

23b. DATE THEREOF

June 6, 1960

23c. NAME OF CEMETERY OR CREMATORIUM

Asbury Cemetery

23d. LOCATION (City, town, or county)

(State)

Arnold, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Bernard Hopping

ADDRESS

Hopping Funeral Home
Annapolis, Md.

25o. REC'D BY REGISTRAR

JUN 8 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06548

6586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanover</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Hill</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>805 Dale Rd</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>	
d. STREET ADDRESS <i>805 Dale Rd</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George Henry Wolf</i>		First <i>George</i>	Middle <i>Henry</i>
4. DATE OF DEATH <i>June 4 1960</i>		Last <i>Wolf</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 12, 1892</i>		9. AGE (In years last birthday) yrs. <i>68</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipping Clerk Same</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>New York</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>A. S. A.</i>	
13. FATHER'S NAME <i>Henry Wolf</i>		14. MOTHER'S MAIDEN NAME <i>Anna Engerhausen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.W. 090-10-7281</i>	
17. INFORMANT <i>Edna Wolf</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO <i>Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Hodgkin's Disease, Nephritis</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 min.</i>	
		3 days.	
		3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>614 —</i>		20f. (City or town) (County) (State) <i>Glen Burnie</i>	
21. I certify that I attended the deceased from _____, <i>2/12 1960</i> , to _____, <i>6/4 1960</i> , that I last saw the deceased alive on _____, <i>6/4 1960</i> , and that death occurred at _____, <i>Glen Burnie</i> , M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>715 COTTER 12d</i>	
ACTUAL SIGNATURE <i>R.W. Richard</i>		DATE SIGNED <i>6/4/60</i>	
PHYSICIAN'S NAME (Type) <i>R.W. Richard</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 7 1960</i>		22b. DATE THEREOF <i>June 7 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Lutheran Cemetery</i>		22d. LOCATION (City, town, or county) <i>New York</i>	
(State) <i>New York</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping & Murphy, Glen Burnie</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 7 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G264 6-15-60 et

6587

CERTIFICATE OF DEATH

Reg. Dist. No.

06550

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		d. STREET ADDRESS <i>113 Central Ave. S.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Senn's Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Theodore</i>	Middle <i>Hamilton</i>	Last <i>Wood</i>	4. DATE OF DEATH 1879 Sept. 9, 1880	Month June	Day 4th	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 Sept. 9, 1880	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elizah Wood</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Shelby</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs Blanche Rollins</i>		Address <i>Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>4221</i> (b) DUE TO (c)		<i>Reactive Pulmonary Edema</i>		<i>Congestive Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
		<i>Cerebral Infarct - Paralysis - Residual</i>		<i>Generalized Edema</i>		<i>3 years</i>	
						<i>1 month</i>	
19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cerebral Infarct - Paralysis - Residual</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6/4/60</i>		20f. (City or town) (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>DR. JOSEPH LIPSON M.D.</i>						ADDRESS (Street, city or town, state) <i>Odenton Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 7, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Brooklyn Park, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard J. Siegle</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 8 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

RECEIVED BY THE DEPARTMENT OF STATE - WASH. - 2772

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6531

CERTIFICATE OF DEATH

Reg. Dist. No. A6551

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>RURAL</i>	b. COUNTY <i>A.A.C.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>217 Hanover St.</i>	e. STREET ADDRESS <i>217 Hanover St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>ELIZABETH J. WORK</i>	First <i>J.</i>	Middle <i>Elizabeth</i>	Last <i>WORK</i>	
4. DATE OF DEATH <i>6 3 1960</i>	Month <i>6</i>	Day <i>3</i>	Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-24-1898</i>	
9. AGE (In years last birthday) <i>68 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	12. BIRTHPLACE (State or foreign country) <i>MICHIGAN</i>	
13. FATHER'S NAME <i>EVAN M. JOHNSON</i>	14. MOTHER'S MAIDEN NAME <i>ELIZABETH S. JOHNSON</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>W.M. O. MC DOWELL</i>	17. INFORMANT <i>M.D.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>D.O.H.</i> 252.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Thyroidic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>8 mon</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank M. Shifley</i>	ADDRESS (Street, city or town, state) <i>121 Cathedral St</i>			DATE SIGNED <i>6-3-60</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>	22b. DATE THEREOF <i>6-6-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln</i>	22d. LOCATION (City, town, or county) <i>Anne Arundel Co., Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons Annapolis, Md.</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE JUN 7 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

